

**UNIVERSITY OF
MARYLAND, BALITMORE**

**Vision Care
Option**

CareFirst of Maryland, Inc.
doing business as
CareFirst BlueCross BlueShield
10455 Mill Run Circle
Owings Mills, MD 21117-5559

A private not-for-profit health service plan incorporated under the laws of the State of Maryland

An independent licensee of the Blue Cross and Blue Shield Association

EVIDENCE OF COVERAGE

This Evidence of Coverage, including any attachments, amendments and riders, is a part of the Group Contract issued to the Group through which the Subscriber is enrolled for health benefits. In addition, the Group Contract includes other provisions that explain the duties of CareFirst and the Group. The Group's payment and CareFirst's issuance make the Group Contract's terms and provisions binding on CareFirst and the Group.

Group Name: University of Maryland, Baltimore

Group Number(s): 1901370

CareFirst of Maryland, Inc.



Chester E. Burrell
President and Chief Executive Officer

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DEFINITIONS

The Evidence of Coverage uses certain defined terms. When these terms are capitalized, they have the following meaning:

Allowed Benefit means:

1. For a Health Care Provider that has contracted with CareFirst, the Allowed Benefit for a Covered Service is the lesser of:
 - a. The actual charge; or
 - b. The amount CareFirst allows for the service in effect on the date that the service is rendered.

The benefit is payable to the Health Care Provider and is accepted as payment in full, except for any applicable Member payment amounts, as stated in the Schedule of Benefits.

2. For a Health Care Provider that has not contracted with CareFirst, the Allowed Benefit for a Covered Service will be determined in the same manner as the Allowed Benefit payable to a Health Care Provider that has contracted with CareFirst. The benefit is payable to the Subscriber, or to the Health Care Provider, at the discretion of CareFirst. The Member is responsible for any applicable Member payment amounts, as stated in the Schedule of Benefits, and for the difference between the Allowed Benefit and the Health Care Provider's actual charge. It is the Member's responsibility to apply any CareFirst payments to the Health Care Provider's charges.

Benefit Period means the period of time during which Covered Services are eligible for payment. The Benefit Period is: January 1st through December 31st.

CareFirst means CareFirst of Maryland, Inc. doing business as CareFirst BlueCross BlueShield.

Coinsurance means the percentage of the Allowed Benefit allocated between CareFirst and the Member whereby CareFirst and the Member share in the payment for Covered Services.

Contract Renewal Date means the date, specified in the Eligibility Schedule, on which this Evidence of Coverage renews and each anniversary of such date.

Convenience Item means any item that increases physical comfort or convenience without serving a Medically Necessary purpose, e.g. elevators, hooyer/stair lifts, ramps, shower/bath bench, items available without a prescription.

Conversion Contract means a non-group health benefits contract issued in accordance with state law to individuals whose coverage through the Group has terminated.

Copayment (Copay) means a fixed dollar amount that a Member must pay for certain Covered Services. When a Member receives multiple services on the same day by the same Health Care Provider, the Member will only be responsible for one Copay.

Cosmetic means the use of a service or supply which is provided with the primary intent of improving appearance, not restoring bodily function or correcting deformity resulting from disease, trauma, or previous therapeutic intervention, as determined by CareFirst.

Covered Service means a Medically Necessary service or supply provided in accordance with the terms of this Evidence of Coverage.

Deductible means the dollar amount of Covered Services based on the Allowed Benefit, which must be Incurred before CareFirst will pay for all or part of remaining Covered Services. The Deductible is met when the Member receives Covered Services that are subject to the Deductible and pays for these him/herself.

Dependent means a Member who is covered under the Evidence of Coverage as the eligible spouse or eligible child.

Effective Date means the date on which the Member's coverage becomes effective. Covered Services rendered on or after the Member's Effective Date are eligible for coverage.

Evidence of Coverage means this agreement, which includes the group application, acceptance and riders and amendments, if any, between the Group and CareFirst. (Also referred to as the Group Contract.)

Experimental/Investigational means a service or supply that is in the developmental stage and in the process of human or animal testing. Services or supplies that do not meet all five of the criteria listed below are deemed to be Experimental/Investigational:

1. The Technology* must have final approval from the appropriate government regulatory bodies;
2. The scientific evidence must permit conclusions concerning the effect of the Technology on health outcomes;
3. The Technology must improve the net health outcome;
4. The Technology must be as beneficial as any established alternatives; and,
5. The improvement must be attainable outside the Investigational settings.

*Technology includes drugs, devices, processes, systems, or techniques.

FDA means the federal Food and Drug Administration.

Group means the Subscriber's employer or other organization to which CareFirst has issued the Group Contract and Evidence of Coverage.

Group Contract means the agreement issued by CareFirst to the Group through which the benefits described in this Evidence of Coverage are made available. In addition to the Evidence of Coverage, the Group Contract includes any riders and/or amendments attached to the Group Contract or Evidence of Coverage and signed by an officer of CareFirst.

Health Care Provider means a health care practitioner licensed or otherwise authorized by law to provide Covered Services.

Incurred means a Member's receipt of a health care service or supply for which a charge is made.

Lifetime Maximum means the maximum dollar amount payable toward a Member's claims for Covered Services while the Member is insured under this Group Contract.

Limiting Age means the maximum age to which an eligible child may be covered under this Evidence of Coverage as stated in the Eligibility Schedule.

Medical Director means a board certified physician who is appointed by CareFirst. The duties of the Medical Director may be delegated to qualified persons.

Medically Necessary Or Medical Necessity means use of a service or supply that is:

1. Commonly and customarily recognized as appropriate in the diagnosis and treatment of a Member's illness or injury;
2. Appropriate with regard to standards of good medical practice;
3. Not solely for the convenience of the Member, his or her physician, hospital, or other Health Care Provider; and,
4. The most appropriate supply or level of service that can be safely provided to the Member.

The term "not Medically Necessary" means the use of a service or supply that does not meet the above criteria for determining medical necessity. The decision as to whether a service or supply is Medically Necessary for purposes of payment by CareFirst rests with the Medical Director or his/her designee; however, such a decision shall in no way affect the provider's/practitioner's determination of whether medical treatment is appropriate as a matter of clinical judgment.

Member means an individual who meets all applicable eligibility requirements, is enrolled either as a Subscriber or Dependent, and for whom the Premiums have been received by CareFirst.

Non-Participating or Non-Par Provider means any Health Care Provider that does not contract with CareFirst.

Open Enrollment means a single period of time in each benefit year during which the Group gives eligible individuals the opportunity to change coverage or enroll in coverage.

Over-the-Counter means any item or supply, as determined by CareFirst, that is available for purchase without a prescription, unless otherwise a Covered Service. This includes, but is not limited to, non-prescription eye wear, family planning and contraception products, cosmetics or health and beauty aids, food and nutritional items, support devices, non-medical items, foot care items, first aid and miscellaneous medical supplies (whether disposable or durable), personal hygiene supplies, incontinence supplies, and Over-The-Counter medications and solutions.

Participating Provider or Par Provider means a Health Care Provider who contracts with CareFirst to be paid directly for rendering Covered Services to Members.

Premium means the dollar amount the Group and/or Subscriber remits for health care benefits under this Evidence of Coverage.

Prescription Drug means a drug, biological or compounded prescription intended for outpatient use that carries the FDA legend "may not be dispensed without a prescription;" and, drugs prescribed for treatments other than those stated in the labeling approved by the FDA, if the drug is recognized for such treatment in standard reference compendia or in the standard medical literature as determined by CareFirst.

Sound Natural Teeth include teeth restored with intra- or extra-coronal restorations (fillings, inlays, onlays, veneers and crowns) and *excludes* any tooth replaced by artificial means (fixed or removable bridges, or dentures).

Specialist means a physician who is certified or trained in a specified field of medicine.

Subscriber means a Member who is covered under this Evidence of Coverage as an eligible employee or eligible participant of the Group, rather than as a Dependent.

Type of Coverage means either Individual coverage, which covers the Subscriber only, or Family Coverage, under which a Subscriber may also enroll his or her Dependents. Some Group Contracts include additional categories of coverage, such as Individual and Adult and Individual and Child. The Types of Coverage available under this Evidence of Coverage are selected by the Group and are stated in the Group Provisions. All types may not be available under a Group's Contract.

Waiting Period means the period of time that must pass before an employee or dependent is eligible to enroll under the terms of this Evidence of Coverage.

ELIGIBILITY AND ENROLLMENT

2.1 Requirements for Coverage

The Group is required to administer all requirements for coverage in strict accordance with the terms that have been agreed to and cannot change the requirements for coverage or make an exception unless CareFirst approves them in advance, in writing. To be covered under the Evidence of Coverage, all of the following conditions must be met:

- A. The individual must be eligible for coverage either as a Subscriber or, if applicable, as a Dependent pursuant to the terms of the Evidence of Coverage;
- B. The individual must elect coverage during certain periods defined in the Evidence of Coverage;
- C. The Group must notify CareFirst of the election in accordance with the Group Contract; and,
- D. Payments must be made by or on behalf of the Member as required by the Group Contract.

NOTE: If both the Subscriber and Dependent spouse qualify as "Subscribers" of the Group they may not enroll under separate memberships; i.e., as separate "Subscribers."

2.2 Eligibility as a Subscriber

To enroll as a Subscriber, the individual must meet the eligibility requirements established by the Group. These requirements are stated in the Eligibility Schedule.

2.3 Eligibility of Subscriber's Spouse

If the Group has elected to include coverage for the Subscriber's spouse under this Evidence of Coverage (see Eligibility Schedule) then a Subscriber may enroll his or her spouse as a Dependent (spouse is a person of the opposite sex who is married to a Subscriber by a ceremony recognized by the law of the state or jurisdiction in which the Subscriber resides).

2.4 Eligibility of Children

If the Group has elected to include coverage for the Subscriber's children under this Evidence of Coverage then a Subscriber may enroll a child as a Dependent as limited below (see Eligibility Schedule). To be eligible, the Dependent child must:

- A. Not have reached the Limiting Age for Dependent children as stated in the Eligibility Schedule;
- B. Be unmarried; and
- C. Be related to the Subscriber, in one of the following ways:
 - 1. The Subscriber's or spouse's Dependent child by birth or legal adoption;
 - 2. Under testamentary or court appointed guardianship, other than temporary guardianship of less than 12 months duration, and who resides with, and is the dependent of, the Subscriber or spouse;
 - 3. A Dependent child who is the subject of a Medical Child Support Order or a Qualified Medical Support Order that creates or recognizes the right of the Dependent child to receive benefits under a parent's health insurance coverage;
 - 4. A grandchild who is in the court-ordered custody, and who resides with, and is the dependent of, the Subscriber or Dependent spouse.

- D. Children whose relationship to the Subscriber is not listed above, including, but not limited to grandchildren (except as provided above), foster children or children whose only relationship is one of legal guardianship (except as provided above) are not covered under this Evidence of Coverage, even though the child may live with the Subscriber and be dependent upon him or her for support.

2.5 **Limiting Age for Dependent Children.**

- A. Dependent children are eligible for coverage up to the Limiting Age for non-students, as stated in the Eligibility Schedule.
- B. Dependent children may be eligible beyond the Limiting Age if they meet the requirements for Student Dependents, as described below. Coverage will be provided up to the Limiting Age for Student Dependents as stated in the Eligibility Schedule.
 - 1. Student Dependent means a Dependent child who is enrolled and whose time is principally devoted to attending school (meets the requirements for full-time status, or shows evidence that attendance is a full-time endeavor).
 - 2. The Member must provide CareFirst with proof of the Dependent child's student status within 31 days after the Dependent child's coverage would otherwise terminate or within 31 days after the Effective Date of the Dependent child's coverage, whichever is later. CareFirst has the right to verify eligibility status.
- C. Coverage for unmarried incapacitated Dependent children/Student Dependents. A Dependent child/Student Dependent covered under this Evidence of Coverage will be eligible for coverage past the Limiting Age if:
 - 1. The Dependent child/Student Dependent is chiefly dependent for support upon the Subscriber or the Subscriber's Dependent spouse; and
 - 2. At the time of reaching the Limiting Age, is incapable of self-support because of mental or physical incapacity that started before the Dependent child/Student Dependent attained the Limiting Age.
 - 3. The Subscriber provides CareFirst with proof of the Dependent child's/Student Dependent's mental or physical incapacity within 31 days after the Dependent child's/Student Dependent's coverage would otherwise terminate. CareFirst has the right to determine whether the child is and continues to qualify as mentally or physically incapacitated.

2.6 **Enrollment Opportunities and Effective Dates**

Eligible individuals may elect coverage as Subscribers or Dependents, as applicable, only during the following times and under the following conditions. If an individual meets these conditions, his or her enrollment will be treated as timely enrollment. Enrollment at other times will be treated as special enrollment and will be subject to the conditions and limitations stated in Special Enrollment Periods.

A. **Open Enrollment Period**

- Open Enrollment changes will be effective on the Open Enrollment effective date stated in the Eligibility Schedule.
- 1. During the Open Enrollment period, the Group will provide an opportunity to all eligible persons to enroll in or transfer coverage between CareFirst and all other alternate health care plans available through the Group.
 - 2. In addition, Subscribers already enrolled in CareFirst may change their Type of Coverage (e.g. from Individual to Family Coverage) and/or add eligible Dependents not previously enrolled under their coverage.

B. Newly Eligible Subscriber

A newly eligible individual and his/her Dependents may enroll and will be effective as stated in the Eligibility Schedule. If such individuals do not enroll within this period and do not qualify for special enrollment as described below, they must wait for the Group's next Open Enrollment period.

C. Special Enrollment Periods

Special enrollment is allowed for certain individuals who lose coverage. Special enrollment is also allowed with respect to certain dependent beneficiaries. Enrollment will be effective as stated in the Eligibility Schedule.

If only the Subscriber is eligible under this Evidence of Coverage and dependents are not eligible to enroll, special enrollment periods for a spouse/Dependent child are not applicable.

a. Special enrollment for certain individuals who lose coverage:

- 1) CareFirst will permit current employees and dependents to enroll for coverage without regard to the dates on which an individual would otherwise be able to enroll under this Evidence of Coverage.
- 2) Individuals eligible for special enrollment.
 - i) When employee loses coverage. A current employee and any dependents (including the employee's spouse) each are eligible for special enrollment in any benefit package offered by the Group (subject to Group eligibility rules conditioning dependent enrollment on enrollment of the employee) if:
 - A) The employee and the dependents are otherwise eligible to enroll;
 - B) When coverage was previously offered, the employee had coverage under any group health plan or health insurance coverage; and
 - C) The employee satisfies the conditions of paragraph a.3)i), ii), or iii) of this section, and if applicable, paragraph a.3)iv) of this section.
 - ii) When dependent loses coverage.
 - A) A dependent of a current employee (including the employee's spouse) and the employee each are eligible for special enrollment in any benefit package offered by the Group (subject to Group eligibility rules conditioning dependent enrollment on enrollment of the employee) if:
 - 1) The dependent and the employee are otherwise eligible to enroll;
 - 2) When coverage was previously offered, the dependent had coverage under any group health plan or health insurance coverage; and
 - 3) The dependent satisfies the conditions of paragraph a.3)i), ii), or iii) of this section, and if applicable, paragraph a.3)iv) of this section.

- B) However, CareFirst is not required to enroll any other dependent unless the dependent satisfies the criteria of this paragraph a.2)ii), or the employee satisfies the criteria of paragraph a.2)i) of this section.
- 3) Conditions for special enrollment.
- i) Loss of eligibility for coverage. In the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions of this paragraph a)3)i) are satisfied at the time the coverage is terminated as a result of loss of eligibility (regardless of whether the individual is eligible for or elects COBRA continuation coverage). Loss of eligibility under this paragraph does not include a loss due to the failure of the employee or dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact). Loss of eligibility for coverage under this paragraph includes, but is not limited to:
 - A) Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the Limiting Age), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by any of the foregoing;
 - B) In the case of coverage offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual);
 - C) In the case of coverage offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual) and no other benefit package is available to the individual;
 - D) A situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits; and
 - E) A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes that individual.

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- ii) Termination of employer contributions. In the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions of this paragraph are satisfied at the time employer contributions towards the employee's or dependent's coverage terminate. Employer contributions include contributions by any current or former employer that was contributing to coverage for the employee or dependent.
- iii) Exhaustion of COBRA continuation coverage. In the case of an employee or dependent who has coverage that is COBRA continuation coverage, the conditions of this paragraph are satisfied at the time the COBRA continuation coverage is exhausted. For purposes of this paragraph, an individual who satisfies the conditions for special enrollment of paragraph a)3)i) of this section, does not enroll, and instead elects and exhausts COBRA continuation coverage satisfies the conditions of this paragraph.
- iv) Written statement. The Group or CareFirst may require an employee declining coverage (for the employee or any dependent of the employee) to state in writing whether the coverage is being declined due to other health coverage only if, at or before the time the employee declines coverage, the employee is provided with notice of the requirement to provide the statement (and the consequences of the employee's failure to provide the statement). If the Group or CareFirst requires such a statement, and an employee does not provide it, the Group and CareFirst are not required to provide special enrollment to the employee or any dependent of the employee under this paragraph. The Group and CareFirst must treat an employee as having satisfied the requirement permitted under this paragraph if the employee provides a written statement that coverage was being declined because the employee or dependent had other coverage; the Group and CareFirst cannot require anything more for the employee to satisfy this requirement to provide a written statement. (For example, the Group and CareFirst cannot require that the statement be notarized.)

- b. Special enrollment with respect to certain dependent beneficiaries:
- 1) Provided the Group provides coverage for dependents, CareFirst will permit the individuals described in paragraph b.2) of this section to enroll for coverage in a benefit package under the terms of the Group's plan, without regard to the dates on which an individual would otherwise be able to enroll under this Evidence of Coverage.
 - 2) Individuals eligible for special enrollment. An individual is described in this paragraph if the individual is otherwise eligible for coverage in a benefit package under the Group's plan and if the individual is described in paragraph b.2)i), ii), iii), iv), v), or vi) of this section.
 - i) Current employee only. A current employee is described in this paragraph if a person becomes a dependent of the individual through marriage, birth, adoption, or placement for adoption.
 - ii) Spouse of a participant only. An individual is described in this paragraph if either:
 - A) The individual becomes the spouse of a participant; or
 - B) The individual is a spouse of a participant and a child becomes a dependent of the participant through birth, adoption, or placement for adoption.
 - iii) Current employee and spouse. A current employee and an individual who is or becomes a spouse of such an employee, are described in this paragraph if either:
 - A) The employee and the spouse become married; or
 - B) The employee and spouse are married and a child becomes a dependent of the employee through birth, adoption, or placement for adoption.
 - iv) Dependent of a participant only. An individual is described in this paragraph if the individual is a dependent of a participant and the individual has become a dependent of the participant through marriage, birth, adoption, or placement for adoption.
 - v) Current employee and a new dependent. A current employee and an individual who is a dependent of the employee, are described in this paragraph if the individual becomes a dependent of the employee through marriage, birth, adoption, or placement for adoption.
 - vi) Current employee, spouse, and a new dependent. A current employee, the employee's spouse, and the employee's dependent are described in this paragraph if the dependent becomes a dependent of the employee through marriage, birth, adoption, or placement for adoption.

D. Newly Eligible Children

If the Group has elected to include coverage for the Subscriber's children under this Evidence of Coverage then a Subscriber may add a child outside the Open Enrollment period as described below. Other than the categories of children listed below, eligible children can only be added to this coverage during the Group's Open Enrollment period or special enrollment period except as stated under the Medical Child Support Orders section of this Evidence of Coverage. Enrollment will be effective as stated in the Eligibility Schedule.

The benefits applicable:

1. For a newborn child shall be payable from the moment of birth and shall continue for 31 days after the date of birth.
2. For an eligible grandchild shall be payable from the date the grandchild is placed in the court-ordered custody of the Subscriber or Dependent spouse and shall continue for 31 days after that date.
3. For a newly adopted child shall be payable from the date of adoption of the child and shall continue for 31 days after the date of adoption of the child.

Adoption means the earlier of a judicial decree of adoption or, the assumption of custody, pending adoption, of a prospective adoptive child by a prospective adoptive parent.

4. For a minor for whom guardianship is granted by court or testamentary appointment shall be payable from the date of appointment and shall continue for 31 days after the date of court or testamentary appointment.

Coverage beyond 31 days may cost an additional Premium. This occurs when the addition of the child changes the Subscriber's Type of Coverage. When additional Premium is due the Subscriber must notify the Group within 31 days of the Effective Date and the additional Premium must be paid. Coverage will not be provided beyond the 31 days of automatic coverage when written notification enrolling the eligible child is not received within the 31-day period and the additional Premium is not paid.

Where the addition of a child does not change the Subscriber's Type of Coverage, CareFirst does not require notification within the first 31 days for coverage to continue beyond the 31-day period; however, CareFirst will not be able to properly process claims for the child until notice is given.

Coverage for a newborn child or newly adopted child or grandchild or a minor for whom guardianship is granted by court or testamentary appointment shall consist of coverage for injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

2.7 **Enrollment Changes Following Spouse's Death or Spouse's Loss of Group Coverage**

A. CareFirst shall allow the addition of a Subscriber's dependent children to the Subscriber's Group Contract at any time and without evidence of insurability if:

1. The dependent children previously were covered under the policy or contract of the Subscriber's spouse and meet the eligibility provisions in this Group Contract; and
2. The Subscriber's spouse has died.

This section applies regardless of whether a Subscriber's dependent children are eligible for any continuation or conversion privileges under the policy or contract of the Subscriber's spouse.

The Subscriber must apply for enrollment provided under this section within six (6) months after the death of the Subscriber's spouse.

B. CareFirst shall allow the addition of a Subscriber's spouse and/or dependent children to the Subscriber's Group Contract at any time and without evidence of insurability if the Subscriber's spouse loses coverage under another group health insurance contract or policy because of the involuntary termination of the spouse's employment other than for cause.

The Subscriber must apply for enrollment provided under this section within six (6) months after the date on which the Subscriber's spouse's group health insurance contract or policy terminates. The dependent children must meet the eligibility provisions in this Group Contract.

2.8 **Eligibility of Individuals Covered Under Prior Continuation Provisions**

A. If, at the time the Group Contract is first issued, a person is covered under a federal or state required continuation provision of the Group's prior health insurance plan, the person will be considered eligible for coverage.

B. If, at the time an individual is first eligible for coverage, a person is covered under a federal or state required continuation provision of the person's prior health insurance plan, the person will be considered eligible for coverage.

C. The coverage will otherwise be subject to the eligibility requirements of the Group Contract.

2.9 **Clerical or Administrative Error**

Clerical or administrative errors by the Group or CareFirst in recording or reporting data will not confer eligibility or coverage upon individuals who are otherwise ineligible under this Evidence of Coverage, nor will such an error make an individual ineligible for coverage.

2.10 **Cooperation and Submission of Information**

CareFirst may require verification from the Group and/or Subscriber pertaining to the eligibility of a Subscriber or Dependent enrolled hereunder. The Group and/or Subscriber agree to cooperate with and assist CareFirst, including providing CareFirst with reasonable access to Group records upon request. In the event information and/or documents required to establish eligibility are not provided to CareFirst within 31 days following a written request to the Group or the Member, as applicable, coverage of such Members may be suspended by CareFirst. If the written request is sent to the Group and the Group fails to respond within 31 days, CareFirst will then send a copy of that request to the Member and allow the Member an additional 31 days to submit the information or documents required to establish eligibility directly to CareFirst. If such information and/or documents are not submitted by or on behalf of the Member within this 31-day period, CareFirst may suspend payment of claims.

2.11 **Proof of Eligibility**

CareFirst retains the right to require proof of relationships or facts to establish eligibility. CareFirst will pay the reasonable cost of providing such proof.

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MEDICAL CHILD SUPPORT ORDERS

3.1 Definitions

- A. Medical Child Support Order (MCSO) means an “order” issued in the format prescribed by federal law; and issued by an appropriate child support enforcement agency to enforce the health insurance coverage provisions of a child support order. An “order” means a judgment, decree or a ruling (including approval of a settlement agreement) that:
1. Is issued by a court or administrative child support enforcement agency of any state or the District of Columbia.
 2. Creates or recognizes the right of a child to receive benefits under a parent’s health insurance coverage; or establishes a parent’s obligation to pay child support and provide health insurance coverage for a child.
- B. Qualified Medical Support Order (QMSO) means a Medical Child Support Order issued under State law, or the laws of the District of Columbia and, when issued to an employer sponsored health plan, one that complies with Section 609(A) of the Employee Retirement Income Security Act of 1974, as amended.

3.2 Eligibility and Termination

- A. Upon receipt of an MCSO/QMSO, when coverage of the Subscriber's family members is available under the terms of the Subscriber's contract then CareFirst will accept enrollment regardless of enrollment period restrictions. If the Subscriber does not enroll the child then CareFirst will accept enrollment from the non-Subscriber custodial parent; or, the appropriate child support enforcement agency of any State or the District of Columbia. If the Subscriber has not completed an applicable waiting period for coverage the child will not be enrolled until the end of the waiting period.

The Subscriber must be enrolled under this Group Contract in order for the child to be enrolled. If the Subscriber is not enrolled when CareFirst receives the MCSO/QMSO, CareFirst will enroll both the Subscriber and the child, without regard to enrollment period restrictions. The Effective Date will be that stated in the Eligibility Schedule for a newly eligible Subscriber and a newly eligible Dependent child.

- B. Enrollment for such a child will not be denied because the child:
1. Was born out of wedlock.
 2. Is not claimed as a dependent on the Subscriber's federal tax return.
 3. Does not reside with the Subscriber.
 4. Is covered under any Medical Assistance or Medicaid program.

- C. Termination. Unless coverage is terminated for non-payment of the premium, a covered child subject to an MCSO/QMSO may not be terminated unless written evidence is provided to CareFirst that:
1. The MCSO/QMSO is no longer in effect;
 2. The child has been or will be enrolled under other comparable health insurance coverage that will take effect not later than the effective date of the termination of coverage; or,
 3. If coverage is provided under an employer sponsored health plan;
 - a. The employer has eliminated family member's coverage for all employees; or
 - b. The employer no longer employs the Subscriber, except if the Subscriber elects continuation under applicable State or federal law the child will continue in this post-employment coverage.

3.3 **Administration**

When the child subject to an MCSO/QMSO does not reside with the Subscriber, CareFirst will:

- A. Send the non-insuring custodial parent ID cards, claims forms, the applicable certificate of coverage or member contract and any information needed to obtain benefits;
- B. Allow the non-insuring custodial parent or a Health Care Provider of a Covered Service to submit a claim without the approval of the Subscriber;
- C. Provide benefits directly to:
 1. The non-insuring parent;
 2. The Health Care Provider of the Covered Services; or
 3. The appropriate child support enforcement agency of any State or the District of Columbia.

TERMINATION OF COVERAGE

4.1 **Disenrollment of Individual Members**

Coverage of individual Members will terminate on the date stated in the Eligibility Schedule for the following reasons.

- A. CareFirst may terminate a Member's coverage as follows.
 - 1. Nonpayment of charges when due, including Premium contribution that may be required by the Group.
 - 2. The Member no longer meets the conditions of eligibility.
 - 3. Fraudulent use of CareFirst membership card on the part of the Member, the alteration or sale of prescriptions by the Member, or an attempt by the Subscriber to enroll non-eligible persons as Dependents.
- B. The Group is required to terminate the Subscriber's coverage and the coverage of the Dependents if the Subscriber is no longer employed by the Group or the Subscriber no longer meets the Group's eligibility requirements for coverage.
- C. The Group is required to notify the Subscriber if a Member's coverage is cancelled. If the Group does not notify the Subscriber, this will not continue the Member's coverage beyond the termination date of coverage. The Member's coverage will terminate on the termination date set forth in the Eligibility Schedule.
- D. Coverage for the Subscriber and Dependents will terminate if the Subscriber cancels coverage through the Group or changes to another health benefits plan offered by the Group.
- E. Except in the case of a Dependent child enrolled pursuant to a Medical Child Support Order or Qualified Medical Support Order, the Dependents' coverage will terminate if the Subscriber changes the Type of Coverage to an Individual or other non-family contract, or makes a written request to CareFirst to remove an eligible Dependent from coverage.
- F. Coverage for Dependents will automatically terminate if they no longer meet the eligibility requirements of the Group Contract because of a change in age, status or relationship to the Subscriber. Coverage of an ineligible Dependent will terminate on the termination date set forth in the Eligibility Schedule.
- G. The Subscriber is responsible for notifying CareFirst (through the Group) of any changes in the status of Dependents that affect their eligibility for coverage. These changes include a divorce, the marriage of a Dependent child, or termination of a Student Dependent's status as a full-time student. If the Subscriber does not notify CareFirst of these types of changes and it is later determined that a Dependent was not eligible for coverage, CareFirst has the right to recover these amounts from the Subscriber or from the Dependent, at CareFirst's option.

CFMI/TERM (4/05)

H. Subject to the Contestability of Coverage provision in the Group Contract, CareFirst can terminate a Member's coverage with 31 days prior written notice if CareFirst determines that the Member:

1. Made an intentional misrepresentation of information that is material to the acceptance of the enrollment form. As a Member, you represent that all information contained in your enrollment form is true, correct and complete to the best of your knowledge and belief.
2. The Member or the Member's representative made fraudulent misstatements related to coverage or benefits.

4.2 **Death of a Subscriber**

In the event of the Subscriber's death, coverage of any Dependents will continue under the Subscriber's enrollment as stated in the Eligibility Schedule under termination of coverage Death of a Subscriber.

4.3 **Effect of Termination**

Except as provided under the Extension of Benefits for Inpatient or Totally Disabled Individuals provision, no benefits will be provided for any services received on or after the date on which the Member's coverage under this Evidence of Coverage terminates. This includes services received for an injury or illness that occurred before the effective date of termination.

4.4 **Reinstatement**

Coverage will not reinstate automatically under any circumstances.

CONTINUATION OF COVERAGE

5.1 Continuation of Eligibility upon Loss of Group Coverage

A. Federal Continuation of Coverage under COBRA

If the Group health benefit plan provided under this Evidence of Coverage is subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), as amended from time to time, and a Member's coverage terminates due to a "Qualifying Event" as described under COBRA, continuation of participation in this Group health benefit plan may be possible. The employer offering this Group health benefit plan is the Plan Administrator. It is the Plan Administrator's responsibility to notify a Member concerning terms, conditions and rights under COBRA. If a Member has any questions regarding COBRA, the Member should contact the Plan Administrator.

B. Uniformed Services Employment and Reemployment Rights Act ("USERRA")

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the Natural Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

If a Member leaves their job to perform military service, the Member has the right to elect to continue their Group coverage including any Dependents for up to 24 months while in the military. Even if continuation of coverage was not elected during the Member's military service, the Member has the right to be reinstated in their Group coverage when reemployed, without any waiting periods or pre-existing condition exclusions except for service-connected illnesses or injuries. If a Member has any questions regarding USERRA, the Member should contact the Plan Administrator.

C. Maryland Continuation of Coverage

When Maryland Continuation applies, the Member may continue coverage under the Evidence of Coverage as described below.

1. Continuation for Spouse and Children after the Subscriber's Death

This provision applies in the event of the death of a Subscriber who was a resident of Maryland, was covered under the Group Contract or predecessor Group contract with the same employer for at least three months and whose coverage included one or more Dependents at the time of death. This provision also applies to a newborn child of the deceased Subscriber born to the surviving spouse after the Subscriber's death. When this provision applies, Dependents of the Subscriber may elect to remain covered under the Group Contract until the earliest of any of the following:

- a. 18 months after the date of the Subscriber's death;
- b. Failure to make timely payment for this continuation coverage;
- c. Enrollment in other group or non-group coverage;
- d. The date on which the Dependent becomes entitled to benefits under Medicare;
- e. The date on which the Dependent elects to terminate coverage under the Group Contract;

- f. With regard to the coverage of a covered child, the date on which the covered child would no longer have been covered under the Group Contract if the Subscriber's death had not occurred, for example if the child marries or attains the Limiting Age; or
- g. The date on which the Group ceases to provide benefits to its employees under the Group Contract.

This continuation coverage must be elected, through submission of a signed election notification form to the Group, within 45 days after the Subscriber's death. The Dependents are responsible for payment through the Group of the full cost of this continuation coverage, which may include a reasonable administrative fee not to exceed 2% of premium, which is payable to and retained by the Group. No evidence of insurability is required.

2. **Continuation for Spouse and Children in the Event of Divorce**

This provision applies in the event of the divorce of a Subscriber who is a resident of Maryland and whose coverage included one or more Dependents at the time of divorce. This provision also applies to a newborn child of the Subscriber born to the former spouse after the date of divorce. When this provision applies, Dependents of the Subscriber may continue to be covered under the Group Contract until the earliest of any of the following:

- a. Termination of the Subscriber's coverage under the Group Contract;
- b. Failure to make timely payment for this continuation coverage;
- c. Enrollment of the Dependent in other group or non-group coverage;
- d. The date on which the Dependent becomes entitled to benefits under Medicare;
- e. With regard to the coverage of a spouse, the last day of the month in which the spouse remarries;
- f. With regard to the coverage of a covered child, the date on which the covered child would no longer have been covered under the Group Contract if the Subscriber's divorce had not occurred, for example if the child marries or attains the Limiting Age;
- g. The effective date of an election by the Dependent to no longer be covered under the Group Contract; or
- h. The date on which the Group ceases to provide benefits to its employees under the Group Contract.

To receive this continued coverage, the Subscriber or the divorced spouse must notify the Group of the divorce no later than:

- a. Sixty (60) days following the divorce if, on the date of the divorce, the Subscriber is covered under the Group Contract or another group health plan offered by the Group; or
- b. Thirty (30) days following the effective date of the Subscriber's coverage under this Evidence of Coverage if, on the date of the divorce, the Subscriber was covered under a group health plan offered through a different employer.

The Subscriber or the former spouse of the Subscriber shall pay to the Group the full cost of the continuation coverage.

3. **State Continuation for Subscriber and Dependents in the Event of Voluntary or Involuntary Termination of Employment for Any Reason Other Than Cause**

This provision applies in the event of the voluntary and involuntary termination of employment of a Subscriber who is a resident of Maryland, who was terminated from employment for any reason other than cause and who was covered under the Group Contract or predecessor Group Contract with the same employer for at least three months prior to the termination of employment.

When this provision applies, the Subscriber and any Dependent who was covered under the Subscriber on the date of termination may elect to remain covered under the Group Contract until the earliest of any of the following:

- a. 18 months after the date of termination of the Subscriber's employment;
- b. Failure to make timely payment for this continuation coverage;
- c. Enrollment in other group or non-group coverage;
- d. The date on which the Subscriber becomes entitled to benefits under Medicare;
- e. The effective date of an election by the Subscriber to no longer be covered under the Group Contract;
- f. The date on which the employer ceases to provide benefits to its employees under a group contract.
- g. With regard to the coverage of a covered child, the date on which the covered child would no longer have been covered under the Group Contract if the Subscriber's employment had not terminated, for example if the child marries or attains the limiting age.

This continuation coverage must be elected, through submission of a signed election notification form to the Group, within 45 days after termination of the Subscriber's employment. The Subscriber is responsible for payment through the Group of the full cost of this continuation coverage that may include a reasonable administrative fee not to exceed 2% of premium, which is payable to and retained by the Group. No evidence of insurability is required.

5.2 **Additional Right to Continue Group Coverage**

This provision applies if the following conditions are met:

- A. The Member was covered under the Group Contract for at least three months prior to termination;
- B. Coverage did not terminate for any of the following reasons:
 - 1. Eligibility for Medicare;
 - 2. Failure to pay premiums (or any applicable portion thereof);
 - 3. Attainment of any Limiting Age specified in the Group Contract.
- C. At the time of termination, the Member must not be:
 - 1. Enrolled in a Health Maintenance Organization;
 - 2. Covered by or eligible for coverage under another group policy;
- D. The Member must elect this continuation coverage through submission of a signed election notification form to the Group within 60 days after termination of coverage. The Group is responsible for notifying the Member of his or her continuation privileges on or before the termination date, but not more than 61 days before. If the notice is late, the election period will be extended for an additional period of time (at least 31 days). However, a late notice may not extend the election period beyond 90 days after the termination of coverage.
- E. When this provision applies, the Subscriber and any Dependent who was covered under the Subscriber on the date of termination may elect to remain covered under the Group Contract until the earliest of any of the following:
 - 1. Six months after the date of termination of the coverage;
 - 2. Failure to make timely payment for this continuation coverage;
 - 3. Enrollment in other group or non-group coverage;
 - 4. The date on which the Subscriber becomes entitled to benefits under Medicare;
 - 5. The effective date of an election by the Subscriber to no longer be covered under this Evidence of Coverage; or
 - 6. With regard to the coverage of a covered child, the date on which the covered child would no longer have been covered under this Evidence of Coverage if the Subscriber's employment had not terminated, for example if the child marries or attains the Limiting Age.

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The Member will be responsible for payment through the Group of the full cost of this continuation coverage. If the Group Contract terminates before the end of the six-month period:

1. The Member may continue his/her coverage by paying Premiums for the remainder of the period directly to CareFirst;
2. CareFirst may impose a Premium surcharge (up to an additional 20 percent).

5.3 **Right to Continue Coverage under Only One Provision**

If a Member is eligible to continue coverage under the Evidence of Coverage under more than one continuation provision, the Member will receive only one such continuation coverage. The Member may select the continuation coverage of his or her choice.

5.4 **Extension of Benefits for Inpatient or Totally Disabled Individuals**

This section applies to hospital, medical or surgical benefits. During an extension period required under this section a Premium may not be charged. Benefits will cease as of 11:59 p.m., Eastern Standard Time, on the Subscriber's termination date unless:

- A. If a Member is Totally Disabled when his/her coverage terminates, CareFirst shall continue to pay covered benefits, in accordance with the Evidence of Coverage in effect at the time the Member's coverage terminates, for expenses incurred by the Member for the condition causing the disability until the earlier of:
1. The date the Member ceases to be Totally Disabled; or
 2. 12 months after the date coverage terminates.

Same Age Group means within the age group including persons three years older and younger than the age of the person claiming eligibility as Totally Disabled.

Substantial Gainful Activity means the undertaking of any significant physical or mental activity that is done (or intended) for pay or profit.

Totally Disabled (or Total Disability) means a condition of physical or mental incapacity of such severity that an individual, considering age, education, and work experience, cannot engage in any kind of Substantial Gainful Activity or engage in the normal activities as a person of the Same Age Group. A physical or mental incapacity is an incapacity that results from anatomical, physiological, or psychological abnormality or condition, which is demonstrable by medically accepted clinical and laboratory diagnostic techniques. CareFirst reserves the right to determine whether a Member is and continues to be Totally Disabled.

- B. If a Member is confined in a hospital on the date that the Member's coverage terminates, CareFirst shall continue to pay covered benefits, in accordance with the Evidence of Coverage in effect at the time the Member's coverage terminates, for the confinement until the earlier of:
1. The date the Member is discharged from the hospital; or
 2. 12 months after the date coverage terminates.

If the Member is Totally Disabled upon his/her discharge from the hospital, the extension of benefits described in paragraph A., above applies; however, an additional 12-month extension of benefits is not provided. An individual is entitled to only one 12-month extension, not an inpatient 12-month extension and an additional Totally Disabled 12-month extension.

- C. This section does not apply if:
1. Coverage is terminated because an individual fails to pay a required Premium;
 2. Coverage is terminated for fraud or material misrepresentation by the individual;
or
 3. Any coverage provided by a succeeding health benefit plan is provided at a cost to the individual that is less than or equal to the cost to the individual of the extended benefit required under this section; and does not result in an interruption of benefits.

CFMI/CONT (R. 7/06)

COORDINATION OF BENEFITS ("COB"); SUBROGATION

7.1 Coordination of Benefits ("COB")

A. Applicability

1. This Coordination of Benefits (COB) provision applies to this CareFirst Plan when a Member has health care coverage under more than one Plan.
2. If this COB provision applies, the Order Of Benefit Determination Rules should be looked at first. Those rules determine whether the benefits of this CareFirst Plan are determined before or after those of another Plan. The benefits of this CareFirst Plan:
 - a. Shall not be reduced when, under the order of determination rules, this CareFirst Plan determines its benefits before another Plan; but
 - b. May be reduced when, under the order of determination rules, another Plan determines its benefits first. The above reduction is described in the Effect on the Benefits section of this CareFirst Plan Evidence of Coverage.

B. Definitions

For the purpose of this COB section, the following terms are defined. The definitions of other capitalized terms are found in the definitions sections of this Evidence of Coverage.

Allowable Expenses means a health care service or expense, including deductibles, coinsurance or copayments, that is covered at least in part by any of the Plans covering the Member, except as set forth below. This means that an expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense. When a Plan provides benefits in the form of services, (for example an HMO or a Closed Panel Plan) the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid.

CareFirst Plan means this Evidence of Coverage.

Claim Determination Period means a calendar year unless a different benefit year basis is specifically stated in the Schedule of Benefits. However, it does not include any part of a year during which a Member has no coverage under this CareFirst Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

Closed Panel Plan means a Plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

Intensive Care Policy means a health insurance policy that provides benefits only when treatment is received in that specifically designated health care facility of a hospital that provides the highest level of care and which is restricted to those patients who are physically, critically ill or injured.

Plan means any health insurance policy, including those of nonprofit health service Plans, and those of commercial group, blanket, and individual policies, any subscriber contracts issued by health maintenance organizations, and any other established programs under which the insured may make a claim. The term Plan includes coverage under a governmental Plan, or coverage required or provided by law. This does not include a State Plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).

The term Plan does not include:

1. An individually underwritten and issued, guaranteed renewable, specified disease policy;
2. An intensive care policy, which does not provide benefits on an expense incurred basis;
3. Coverage regulated by a motor vehicle reparation law;
4. The first \$100 per day of a Hospital indemnity contract; or,
5. An elementary and or secondary school insurance program sponsored by a school or school system.

Primary Plan Or Secondary Plan means the order of benefit determination rules state whether this CareFirst Plan is a Primary Plan or Secondary Plan as to another Plan covering the Member.

1. When this CareFirst Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.
2. When this CareFirst Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.
3. When there are more than two Plans covering the Member, this CareFirst Plan may be a Primary Plan as to one of the other Plans, and may be a Secondary Plan as to a different Plan or Plans.

Specified Disease Policy means a health insurance policy that provides (1) benefits only for a disease or diseases specified in the policy or for the treatment unique to a specific disease; or (2) additional benefits for a disease or diseases specified in the policy or for treatment unique to a specified disease or diseases.

C. **Order of Determination Rules**

1. **General**
When there is a basis for a claim under this CareFirst Plan and another Plan, this CareFirst Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless;
 - a. The other Plan has rules coordinating benefits with those of this CareFirst Plan; and
 - b. Both those rules and this CareFirst Plan's rules require that this CareFirst Plan's benefits be determined before those of the other Plan.

2. **Rules**

This CareFirst Plan determines its order of benefits using the first of the following rules which applies:

- a. Non-dependent/dependent. The benefits of the Plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the Plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary, and the result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

- 1) Secondary to the Plan covering the person as a dependent, and
- 2) Primary to the Plan covering the person as other than a dependent (e.g. retired employee),

then the benefits of the Plan covering the person as a dependent are determined before those of the Plan covering the person as other than a dependent.

- b. Dependent child/parents not separated or divorced. When this CareFirst Plan and another Plan cover the same child as a dependent of different persons, called "parents:"

- 1) The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in the year; but
- 2) If both parents have the same birthday, the benefits of the Plan that covered one parent longer are determined before those of the Plan that covered the other parent for a shorter period of time.

However, if the other Plan does not have the rule described in 1) immediately above, but instead has a rule based upon the gender of the parent, and if as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

- c. Dependent child/parents separated or divorced. If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

- 1) First, the Plan of the parent with custody of the child;
- 2) Then, the Plan of the spouse of the parent with the custody of the child; and
- 3) Finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. The Plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

- d. Joint custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child follow the order of benefit determination rules outlined in paragraph describing Dependent child/parents not separated or divorced.
- e. Active/inactive employee. The benefits of a Plan which covers a person as an employee who is neither laid off nor retired are determined before those of a Plan which covers that person as a laid off or retired employee. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
- f. Continuation coverage. If a person whose coverage is provided under the right of continuation pursuant to Federal or State law also is covered under another Plan, the following shall be the order of benefits determination:
 - 1) First, the benefits of a Plan covering the person as an employee, member or Subscriber (or as that person's dependent);
 - 2) Second, the benefits under the continuation coverage.

If the other Plan does not have the rule described above, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
- g. Longer/shorter length of coverage. If none of the above rules determines the order of benefits, the benefits of the Plan that covered an employee, member or subscriber longer are determined before those of the Plan that covered that person for the shorter term.

D. Effect on the Benefits of this CareFirst Plan

1. When this Section Applies

This section applies when, in accordance with the prior section, order of benefits determination rules, this CareFirst Plan is a Secondary Plan as to one or more other Plans. In that event the benefits of this CareFirst Plan may be reduced under this section. Such other Plan or Plans are referred to as "the other Plans" immediately below.

2. Reduction in this CareFirst Plan's Benefits

The benefits under this CareFirst Plan will be reduced when the sum of:

- a. The benefits that would be payable for the Allowable Expense under this CareFirst Plan in the absence of this COB provision; and
- b. The benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made; exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of this CareFirst Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

When the benefits of this CareFirst Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this CareFirst Plan.

- E. **Right To Receive And Release Needed Information**
Certain facts are needed to apply these COB rules. CareFirst has the right to decide which facts it needs. It may get the needed facts from or give them to any other organization or person for purposes of treatment, payment, and health care operations. CareFirst need not tell, or get the consent of, any person to do this. Each person claiming benefits under this CareFirst Plan must give this CareFirst Plan any facts it needs to pay the claim.
- F. **Facility Of Payment**
A payment made under another Plan may include an amount that should have been paid under this CareFirst Plan. If it does, this CareFirst Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this CareFirst Plan. This CareFirst Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.
- G. **Right Of Recovery**
If the amount of the payments made by this CareFirst Plan is more than it should have paid under this COB provision, it may recover the excess from one or more of:
1. The persons it has paid or for whom it has paid,
 2. Insurance companies, or,
 3. Other organizations.
- The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

7.2 **Employer or Governmental Benefits**

Coverage under this Evidence of Coverage does not include the cost of services or payment for services for any illness, injury or condition for which, or as a result of which, a Benefit (as defined below) is provided or is required to be provided either:

- A. Under any federal, state, county or municipal workers' compensation or employer's liability law or other similar program; or
- B. From any federal, state, county or municipal or other government agency, including, in the case of service-connected disabilities, the Veterans Administration, to the extent that benefits are payable by the federal, state, county or municipal or other government agency, but excluding Medicare benefits and Medicaid benefits.

Benefit as used in this provision includes a payment or any other benefit, including amounts received in settlement of a claim for Benefits.

CFMI/COB; SUBRO (4/05)

7.3 **Subrogation**

CareFirst has subrogation and reimbursement rights. Subrogation requires the Member to turn over to CareFirst any rights the Member may have against a third party. A third party is any person, corporation, insurer or other entity that may be liable to a Member for an injury or illness. This right applies to the amount of benefits paid by CareFirst for injuries or illnesses where a third party could be liable.

Recovery means to be successful in a lawsuit, to collect or obtain an amount; to obtain a favorable or final judgment; to obtain an amount in any legal manner; an amount finally collected or the amount of judgment as a result of an action brought against a third-party. A Recovery does not include payments made to the Member under the Member's Personal Injury Protection Policy. CareFirst will not recover medical expenses from a Subscriber unless the Subscriber or Member recovers for medical expenses in a cause of action.

- A. The Member shall notify CareFirst as soon as reasonably possible that a third-party may be liable for the injuries or illnesses for which benefits are being provided or paid.
- B. To the extent that actual payments made by CareFirst result from the occurrence that gave rise to the cause of action, CareFirst shall be subrogated and succeed to any right of recovery of the Member against any person or organization.
- C. The Member shall pay CareFirst the amount recovered by suit, settlement, or otherwise from any third-party's insurer, any uninsured or underinsured motorist coverage, or as permitted by law, to the extent that any actual payments made by CareFirst result from the occurrence that gave rise to the cause of action.
- D. The Member shall furnish information and assistance, and execute papers that CareFirst may require to facilitate enforcement of these rights. The Member shall not commit any action prejudicing the rights and interests of CareFirst.
- E. In a subrogation claim arising out of a claim for personal injury, the amount recovered by CareFirst shall be reduced by:
 1. Dividing the total amount of the personal injury recovery into the total amount of the attorney's fees incurred by the injured person for services rendered in connection with the injured person's claim; and
 2. Multiplying the result by the amount of CareFirst's subrogation claim. This percentage may not exceed one-third (1/3) of CareFirst's subrogation claim.
- F. On written request by CareFirst, a Member or Member's attorney who demands a reduction of the subrogation claim shall provide CareFirst with a certification by the Member that states the amount of the attorney's fees incurred.
- G. These provisions do not apply to residents of the Commonwealth of Virginia.

VISION CARE BENEFITS DESCRIPTION OF COVERED SERVICES

The services described herein are eligible for coverage under this Evidence of Coverage. CareFirst will provide the benefits described in the Schedule of Benefits for Medically Necessary Covered Services Incurred by a Member, including any extension of benefits for which the Member is eligible. It is important to refer to the Schedule of Benefits to determine the percentage of the Allowed Benefit that CareFirst will pay and any specific limits on the number of services that will be covered. The Schedule of Benefits also lists important information about Deductibles, Out-of-Pocket Maximums and other features that affect Member coverage, including the annual Deductible, specific benefit limitations and, if applicable, the Lifetime Maximum.

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SECTION A – HOW THE PLAN WORKS

This health care benefits plan offers a choice of Health Care Providers. Payment depends on the Health Care Provider chosen, as explained below in Choosing a Provider. Other factors that may affect payment are found in Coordination of Benefits (“COB”); Subrogation and Exclusions.

Medical Necessity

CareFirst will pay a benefit for Covered Services rendered by a Health Care Provider only when Medically Necessary as determined by CareFirst. Benefits are subject to all of the terms, conditions, and maximums, if applicable, as stated in this Evidence of Coverage.

Choosing a Provider

CareFirst has contracted with Davis Vision, Inc., a national provider of vision care services, to administer vision care benefits. Davis Vision, Inc. has special agreements with optometrists and ophthalmologists to provide vision care benefits to Members. These optometrists and ophthalmologists are In-Network Providers. If a Member chooses to obtain vision care from an In-Network Provider, the cost to the Member is lower than if the Member chooses an Out-of-Network Provider. A vision care benefits Out-of-Network Provider is always considered a Non-Participating Provider. Throughout the Schedule of Benefits, payments are listed as either “In-Network” or “Out-of-Network.” Hereafter, references to CareFirst shall also include Davis Vision, Inc.

Member/Health Care Provider Relationship

1. The Member has the exclusive right to choose a Health Care Provider. Whether a Health Care Provider is a Participating Provider or not relates only to method of payment, and does not imply that any Health Care Provider is more or less qualified than another.
2. CareFirst makes payment for Covered Services, but does not provide these services. CareFirst is not liable for any act or omission of any Health Care Provider.

Participating Providers; In-Network Providers

1. Claims will be submitted directly to CareFirst by the Health Care Provider.
2. CareFirst will pay benefits directly to the Health Care Provider.
3. The Member is responsible for any applicable Deductible and Coinsurance or Copayment and balance due after CareFirst's payment unless otherwise stated.

Non-Participating Providers; Out-of-Network Providers

1. Claims may be submitted directly to CareFirst or its designee by the Health Care Provider, or the Member may need to submit the claim. In either case, it is the responsibility of the Member to make sure that proofs of loss are filed on time.
2. All benefits for Covered Services rendered by a Non-Participating Provider will be payable to the Subscriber, or to the Health Care Provider, at the discretion of CareFirst.
3. In the case of a Dependent child enrolled pursuant to a Medical Child Support Order or a Qualified Medical Support Order, payment will be paid directly to the Department of Health and Mental Hygiene or the noninsuring parent if proof is provided that such parent has paid the Health Care Provider.
4. The Member is responsible for the difference between CareFirst's payment and the Non-Participating Provider's charge.

Notice of Claim

A Member may request a claim form by writing or calling CareFirst. CareFirst does not require written notice of a claim.

Claim Forms

CareFirst provides claim forms for filing proof of loss. If CareFirst does not provide the claim forms within 15 days after notice of claim is received, the Member is considered to have complied with the requirements of this Evidence of Coverage as to proof of loss if the Member submits, within the time fixed in this Evidence of Coverage for filing proof of loss, written proof of the occurrence, character, and extent of the loss for which the claim is made.

Proofs of Loss

In order to receive benefits for services rendered by a Non-Participating Provider, a Member must submit written proof of loss to CareFirst or its designee within the deadlines described below.

Claims for Vision Care Benefits must be submitted within twelve (12) months following the dates services were rendered.

A Member's failure to furnish the proof of loss within the time required does not invalidate or reduce a claim if it was not reasonably possible to submit the proof within the required time, if the proof is furnished as soon as reasonably possible, and except in the absence of legal capacity of the member, not later than one year from the time proof is otherwise required.

CareFirst will honor claims submitted for Covered Services by any agency of the federal, state or local government that has the statutory authority to submit claims beyond the time limits established under this Evidence of Coverage. These claims must be submitted to CareFirst before the filing deadline established by the applicable statute on claims forms that provide all of the information CareFirst deems necessary to process the claim. CareFirst provides forms for this purpose.

Time of Payment of Claims

Benefits payable under this Evidence of Coverage will be paid not more than 30 days after receipt of written proof of loss.

CFMI/VISION (4/05)

Claim Payments Made in Error

If CareFirst makes a claim payment to or on behalf of a Member in error, the Member is required to repay CareFirst the amount that was paid in error. If the Member has not repaid the full amount owed CareFirst and CareFirst makes a subsequent benefit payment, CareFirst may subtract the amount owed CareFirst from the subsequent payment.

Legal Action

No legal action may be brought to recover on this Evidence of Coverage prior to 60 days after a written proof of loss for benefits has been filed and unless brought within three (3) years from the date the claim for benefits is required to be submitted.

Assignment of Benefits

A Member may not assign his or her right to receive benefits or benefit payments under this Evidence of Coverage to another person or entity except for routine assignment of benefit payments to Participating Providers rendering Covered Services.

Certificates

Unless CareFirst makes delivery directly to the Subscriber, CareFirst will provide the Group, for delivery to each Subscriber, a statement that summarizes the essential features of the coverage of the Subscriber and that indicates to whom benefits are payable. Only one statement will be issued for each family unit.

Notices

Notices to Members required under the Evidence of Coverage shall be in writing directed to the Subscriber's last known address. It is the Subscriber's responsibility to notify the Group, and the Group's responsibility to notify CareFirst of an address change.

Privacy Statement

CareFirst shall comply with state, federal and local laws pertaining to the dissemination or distribution of non-public personally identifiable medical or health-related data. In that regard, CareFirst will not provide to the plan sponsor named herein or unauthorized third parties any personally identifiable medical information without the prior written authorization of the patient or parent/guardian of the patient or as otherwise permitted by law.

SECTION B – VISION CARE BENEFITS

Benefits are available for:

1. A vision exam which may include:
 - a. Case history;
 - b. External exam of eye and adnexa;
 - c. Ophthalmoscopic exams;
 - d. Determination of refractive status;
 - e. Binocular balance test;
 - f. Tonometry test for glaucoma;
 - g. Gross visual fields;
 - h. Color vision test;
 - i. Summary finding;
 - j. Recommendations, including prescription of corrective lenses.
2. Prescribed frames and lenses or contact lenses including directly related Health Care Provider services such as:
 - a. Measurement of face and interpupillary distance;
 - b. Quality assurance;
 - c. Reasonable aftercare to fit, adjust, and maintain comfort and effectiveness;
 - d. Help in choosing frames.
3. One pair of frames.
4. One pair of prescription lenses:
 - a. Single or multi vision;
 - b. Tinted; or
 - c. Sunglasses.
5. One pair of prescription contact lenses, or multiple pairs of prescription contact lenses if the Member selects disposable contact lenses.
 - a. When Medically Necessary as a result of cataract surgery; or when visual acuity of at least 20/70 in the better eye can be obtained only by use of contact lenses.

The Member must obtain prior authorization by contacting CareFirst at the telephone number on the Member's identification card.
 - b. At the election of the Member (in place of frames and lenses).

SECTION C – EXCLUSIONS

Note: these exclusions are in addition to the exclusions in the attached Evidence of Coverage.

Benefits are not provided for:

1. Diagnostic services, except as may be necessary for a vision exam.
2. Medical care or surgery.
3. Prescription Drugs, except as may be necessary for a vision exam.
4. Orthoptics, vision training, and low vision aids.
5. Except as otherwise provided, vision care services for Cosmetic use.
6. Services or supplies for which prior authorization is required but not obtained.
7. Replacement, within the same Benefit Period, of frames, lenses or contact lenses that were lost or broken.
8. Non-prescription glasses, sunglasses or contact lenses.

SECTION D – EXTENSION OF BENEFITS

During an extension period under this Evidence of Coverage, Premium may not be charged.

Benefits will cease as of 11:59 p.m., Eastern Standard Time, on the Subscriber's termination date.

If a Member has ordered lenses and frames or contact lenses before the date coverage terminates, CareFirst will provide coverage for the lenses and frames or contact lenses if received within 30 days after the date of the order.

This extension of benefits will not apply if:

1. Coverage is terminated for non-payment of the required Premium by the Member; or
2. Coverage is terminated for fraud or material misrepresentation by the Member; or
3. The member obtained uninterrupted and comparable coverage under a succeeding vision plan that is less than the cost to the Member of the extended benefit.

SECTION E – SCHEDULE OF BENEFITS

CareFirst pays only for Covered Services. The Member pays for services, supplies or care which are not covered. The Member pays any applicable Deductible, and Coinsurance or Copayment and balance due after CareFirst’s payment unless otherwise stated. Services that are not listed herein, or are listed in Exclusions, are not Covered Services.

When determining the benefits a Member may receive, CareFirst considers all provisions of this Evidence of Coverage.

Unless otherwise stated for a particular Covered Service:

Benefit Period

The Benefit Period is 12 months from the first Covered Service. Benefits are limited to once per Benefit Period.

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Vision Exam In-Network: The Member payment is \$10 Out-of-Network: The Member payment is the balance after CareFirst’s payment	100% of Allowed Benefit after \$10 Copay	\$ 45

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Frames chosen from an In-Network Provider’s display of selected frames In-Network: The Member payment is zero	100% of Allowed Benefit	Not Applicable
Frames not chosen from an In-Network Provider’s display of selected frames and/or frames from an Out-of-Network Provider In and Out-of-Network: The Member payment is the balance after CareFirst’s payment	\$ 45	\$ 45

Important note regarding Member Payments:

The Member payment is zero for “Basic” single vision, bifocal, trifocal and lenticular lenses when lenses are provided by an In-Network Provider; otherwise the Member payment is the balance after CareFirst’s payment. “Basic” means lenses with no “add-ons” such as scratch-resistant/UV coating, progressive/transitional lenses, etc.

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Lenses		
<p>Basic single vision</p> <p>In-Network: The Member payment is zero</p> <p>Out-of-Network: The Member payment is the balance after CareFirst's payment</p>	100% of Allowed Benefit	\$ 52
<p>Basic bifocal</p> <p>In-Network: The Member payment is zero</p> <p>Out-of-Network: The Member payment is the balance after CareFirst's payment</p>	100% of Allowed Benefit	\$ 82
<p>Basic trifocal</p> <p>In-Network: The Member payment is zero</p> <p>Out-of-Network: The Member payment is the balance after CareFirst's payment</p>	100% of Allowed Benefit	\$ 101
<p>Basic lenticular</p> <p>In-Network: The Member payment is zero</p> <p>Out-of-Network: The Member payment is the balance after CareFirst's payment</p>	100% of Allowed Benefit	\$ 181

Important note regarding Member Payments:

The Member payment is zero for select elective contact lenses provided by an In-Network Provider; otherwise, the Member payment is the balance after CareFirst's payment.

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Contact Lenses		
<p>Medically Necessary</p> <p>In-Network: The Member payment is zero</p> <p>Out-of-Network: The Member payment is the balance after CareFirst's payment</p>	100% of Allowed Benefit	\$ 285
Elective contact lenses		
<p>Select single vision elective, including disposable contact lenses (in place of frames and lenses)</p> <p>In-Network: The Member payment is zero</p>	100% of Allowed Benefit	Not Applicable
<p>Any other single vision elective, including disposable contact lenses</p> <p>In and Out-of-Network: The Member payment is the balance after CareFirst's payment</p>	\$ 97	\$ 97
<p>Select bifocal elective, including disposable contact lenses (in place of frames and lenses)</p> <p>In-Network: The Member payment is zero</p>	100% of Allowed Benefit	Not Applicable
<p>Any other bifocal elective, including disposable contact lenses</p> <p>In and Out-of-Network: The Member payment is the balance after CareFirst's payment</p>	\$ 127	\$127

EXCLUSIONS

This section lists services or conditions for which benefits are not available under this Evidence of Coverage.

CareFirst will not provide a benefit for:

- Any service, supply or item that is not Medically Necessary. Although a service may be listed as covered, benefits will be provided only if the service is Medically Necessary as determined by CareFirst.
- Services that are Experimental/Investigational or not in accordance with accepted medical standards in effect at the time the service in question is rendered, as determined by CareFirst.
- Services or supplies received at no charge to a Member in any federal hospital, or through any federal, state or local governmental agency or department, or not the legal obligation of the Member, or where the charge is made only to insured persons.

This exclusion does not apply to:

1. Medicaid;
 2. Benefits provided in any state, county, or municipal hospital in or out of the state of Maryland;
 3. Care received in a Veteran's hospital unless the care is rendered for a condition that is a result of a Member's military service.
- Services that are not specifically shown in this Evidence of Coverage as a Covered Service or that do not meet all other conditions and criteria for coverage, as determined by CareFirst. Provision of services, even if Medically Necessary, by a Participating Provider does not, by itself, entitle a Member to benefits if the services are excluded or do not otherwise meet the conditions and criteria for coverage.
 - Cosmetic services.
 - Treatment rendered by a Health Care Provider who is the Member's parent, child, grandparent, grandchild, sister, brother, great grandparent, great grandchild, aunt, uncle, niece, or nephew or resides in the Member's home.
 - All non-prescription drugs, medications, biologicals, and Over-the-Counter disposable supplies, routinely obtained and self-administered by the Member, except as stated in the Description of Covered Services. Over-the-Counter means any item or supply, as determined by CareFirst, that is available for purchase without a prescription, unless otherwise a Covered Service, or allowed under Case Management, if applicable (see Utilization Management Requirements). This includes, but is not limited to, non-prescription eye wear, family planning and contraception products, cosmetics or health and beauty aids, food and nutritional items, support devices, non-medical items, foot care items, first aid and miscellaneous medical supplies (whether disposable or durable), personal hygiene supplies, incontinence supplies, and Over-the-Counter medications and solutions.
 - Services furnished as a result of a referral prohibited by law.

- Non-medical, Health Care Provider services, including, but not limited to:
 1. Telephone consultations, charges for failure to keep a scheduled visit, completion of forms, copying charges or other administrative services provided by the Health Care Provider or his/her staff.
 2. Administrative fees charged by a Health Care Provider to a Member to retain the Health Care Provider's medical practices services, e.g., "concierge fees" or boutique medical practice membership fees. Benefits under this Evidence of Coverage are limited to Covered Services rendered to a Member by a Health Care Provider.
- Services related to an excluded service (even if those services or supplies would otherwise be Covered Services).
- Separate billings for health care services or supplies furnished by an employee of a Health Care Provider which are normally included in the Health Care Provider's charges and billed for by them.
- Services that are non-medical in nature, including, but not limited to personal hygiene, Cosmetic and convenience items, including, but not limited to, air conditioners, humidifiers, exercise equipment, elevators or ramps.
- Personal comfort items.
- Services performed or prescribed by or under the direction of a person who is not a Health Care Provider.
- Services performed or prescribed by or under the direction of a person who is acting beyond his/her scope of practice.
- Services provided through a dental or medical department of an employer; a mutual benefit association, a labor union, a trust, or a similar entity.
- Services rendered or available under any Worker's Compensation or occupational disease, or employer's liability law, or any other similar law, even if a Member fails to claim benefits. Exclusions to these laws exist for partnerships, sole proprietorships and officers of closed corporations. If a Member is exempt from the above laws, the benefits of this Evidence of Coverage will be provided for Covered Services.
- Services provided or available through an agent of a school system in response to the requirements of the Individuals With Disabilities Education Act and Amendments, or any similar state or federal legislation mandating direct services to disabled students within the educational system, even when such services are of the nature that they are Covered Services when provided outside the educational domain.
- Illnesses resulting from an act of war.
- Charges used to satisfy a Member's dental care, Prescription Drug, or vision care benefits Deductible, if applicable, or balances from any such programs.
- Medical or surgical treatment of myopia or hyperopia. Coverage is not provided for radial keratotomy and any other forms of refractive keratoplasty, or any complications.

ELIGIBILITY SCHEDULE

ELIGIBILITY	
The following persons are eligible for benefits under this Evidence of Coverage:	
Subscriber	<p>A person eligible under guidelines defined by the Group:</p> <p>a student who attends the University of Maryland, Baltimore or an affiliated institution as an admitted or continuing candidate in a recognized degree or certificate program sponsored by the institution. “Candidacy in a recognized degree or certificate program” is defined as</p> <p>a. Candidacy during academic semester</p> <p>A student is an admitted or continuing candidate in a recognized degree or certificate program if the student is actively pursuing the course of study required by the degree or certificate program. The student must satisfy the requirements of his course of study which may involve maintaining minimum credit hours, research units or involvement in approved intern or work/study programs. Academic semester may include summer sessions. Additionally, eligibility may be defined as continuing education courses, affiliated research assistantships, or post doctoral research after graduation from a recognized degree program (e.g., a student fellowship).</p> <p>b. Candidacy between academic semesters</p> <p>A student who maintains candidacy in a recognized degree or certificate program during an academic semester or session keeps such candidacy until the close of the next semester’s or session’s registration period.</p> <p>A student’s eligibility may continue in this manner until the student’s candidacy is withdrawn by the student or terminated by the institution.</p>
Spouse	Coverage for a spouse is available.
Domestic Partner	Coverage for a Domestic Partner is available.
Dependent Children	Coverage for Dependent children is available. Coverage for Dependent children, including children of a Domestic Partner, is available.
Individuals covered under prior continuation provision:	Coverage for a person whose coverage was being continued under a continuation provision of the Group’s prior health insurance plan is available
	Coverage for a person whose coverage was being continued under a continuation provision of the Subscriber’s prior health insurance plan is available
Limiting Age for Dependent children. The Limiting Age is not applicable to unmarried incapacitated Dependent children/incapacitated Student Dependents	Up to age 26

EFFECTIVE DATES	
Open Enrollment	The Group's Contract Date
Newly eligible Subscriber	<p>The date defined by the Group, which is: the enrollment period defined by the Group during which a Subscriber must apply for coverage under this Evidence of Coverage.</p> <p>A Subscriber who is not enrolled when CareFirst receives a Qualified Medical Support Order is eligible for coverage effective on the date specified in the Medical Child Support Order</p>

CFMI/ELIG SCHED (R. 10/07)

EFFECTIVE DATES	
Dependents of a newly eligible Subscriber	The date defined by the Group, which is: the enrollment period defined by the Group during which a Subscriber must apply for coverage under this Evidence of Coverage.

EFFECTIVE DATES	
Newly eligible spouse	The date of marriage
Newly eligible Dependent child	<p>Newly born Dependent child: the date of birth.</p> <p>Adopted Dependent child: the date of adoption, which is the earlier of the date a judicial decree of adoption is signed; or the assumption of custody, pending adoption, of a prospective adoptive child by a prospective adoptive parent.</p> <p>Testamentary or court appointed guardianship of a Dependent child: the date of appointment.</p> <p>Dependent child who is the subject of a Medical Child Support Order or Qualified Medical Support Order that creates or recognizes the right of the Dependent child to receive benefits under a parent's health insurance coverage:</p> <p><u>Medical Child Support Order</u>: the date specified in the Medical Child Support Order.</p> <p><u>Qualified Medical Support Order</u>: the date specified in the Medical Child Support Order.</p> <p>A grandchild who is in the court-ordered custody, and who resides with, and is the dependent of, the Subscriber or spouse: the date of placement of a grandchild in the court-order custody of the Subscriber or spouse.</p>
Dependent child following spouse's death or Dependent child or spouse following spouse's loss of group coverage	<p>If notice was given w/in 31 days after coverage was lost: The date prior coverage terminated.</p> <p>After the 31st day: The first of the month following acceptance of the application.</p>
Individuals whose coverage was being continued under the Group's prior health insurance plan	The Group's Contract Date
Dependents of the individual being continued under the individual's prior health insurance plan	An individual will be effective as stated above for a Dependent of a Newly eligible Subscriber

SPECIAL ENROLLMENT PERIODS

<p>Special enrollment for certain individuals who lose coverage</p>	<p>The employee must notify the Group, and the Group must notify CareFirst no later than 30 days after the exhaustion of the other coverage described or termination of the other coverage as a result of the loss of eligibility for the other coverage described or following the termination of employer contributions toward that other coverage. However, in the case of loss of eligibility for coverage due to the operation of a lifetime limit on all benefits, the Group and CareFirst will allow the employee a period of at least 30 days after a claim is denied due to the operation of a lifetime limit on all benefits.</p> <p>A new Subscriber and/or his/her Dependents is effective on the first of the month following acceptance of the enrollment form by CareFirst</p>
<p>Special enrollment for certain dependent beneficiaries</p>	<p>The employee must notify the Group, and the Group must notify CareFirst during the 31-day special enrollment period beginning on the date of the marriage, birth, or adoption or placement for adoption</p> <p>A new Subscriber and/or his/her Dependents is effective as follows:</p> <p>In the case of marriage: the date of marriage.</p> <p>In the case of a newly born child: the date of birth.</p> <p>In the case of an adopted child: the date of adoption, which is the earlier of the date a judicial decree of adoption is signed; or the assumption of custody, pending adoption, of a prospective adoptive child by a prospective adoptive parent.</p>

TERMINATION OF COVERAGE

Subscriber no longer eligible	A Subscriber and his/her Dependents will remain covered until the end of the month the Subscriber's eligibility ceases under the terms of the Evidence of Coverage
Dependent child	A Dependent child will remain covered until the end of the calendar year when eligibility ceases under the terms of the Evidence of Coverage
Dependent spouse no longer eligible	A Dependent spouse will remain covered until the end of the month when eligibility ceases under the terms of the Evidence of Coverage
Nonpayment of charges	Coverage will terminate on the date stated in CareFirst's written notice of termination
Fraudulent use of CareFirst membership card on the part of the Member, the alteration or sale of prescriptions by the Member, or an attempt by the Subscriber to enroll non-eligible persons as Dependents	Coverage will terminate on the date stated in CareFirst's written notice of termination
Subscriber cancels coverage through the Group or changes to another health benefits plan offered by the Group	Coverage will terminate at the end of the month the Subscriber cancels coverage through the Group or changes to another health benefits plan offered by the Group
Subscriber changes the Type of Coverage to an Individual or other non-family contract, (except in the case of a Dependent child enrolled pursuant to a court or administrative order or Qualified Medical Support Order)	Coverage will terminate at the end of the month the Subscriber changes the Type of Coverage to an Individual or other non-family contract
Death of a Subscriber	Coverage of any Dependents will terminate at the end of the month in which the Subscriber dies

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DOMESTIC PARTNER ELIGIBILITY RIDER

This rider contains certain terms that have a specific meaning as to the eligibility of a Domestic Partner and the Dependent Children of a Domestic Partner. These terms are capitalized and are defined in Section A, in the subsequent sections or in the Evidence of Coverage to which this rider is attached.

This rider is issued by CareFirst to be attached to and become a part of the Evidence of Coverage. A Member's effective date of coverage under this rider and termination date of coverage under this rider are the same as the Member's effective date and termination date under the Evidence of Coverage.

This rider contains specific requirements applicable to Domestic Partner eligibility and the eligibility of a Dependent Child of a Domestic Partner that are in addition to the eligibility requirements of the Subscriber and other Dependents contained in the Evidence of Coverage to which this rider is attached.

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SECTION A – DEFINITIONS
SECTION B – ELIGIBILITY AND ENROLLMENT
SECTION C – CONTINUATION OF COVERAGE
SECTION D – CONVERSION PRIVILEGE

SECTION A - DEFINITIONS

The definition of Dependent in the Evidence of Coverage is deleted and replaced with the following:

Dependent means a Member who is covered under this Evidence of Coverage as the eligible spouse, eligible Dependent Child, eligible Domestic Partner of a Subscriber, or eligible Dependent Child of a Domestic Partner.

The Evidence of Coverage is amended to add the following definitions:

Domestic Partner means a person who cohabitates/resides with the Subscriber in a Domestic Partnership.

Domestic Partnership means a relationship between the Subscriber and Domestic Partner that meets the criteria as stated in Section B.1.b.

SECTION B - ELIGIBILITY AND ENROLLMENT

The Evidence of Coverage is amended to include the following:

1. **Eligibility of Subscriber's Domestic Partner.** The Subscriber may enroll his/her eligible Domestic Partner. An eligible Domestic Partner will be eligible for coverage to the same extent as a Subscriber's spouse.

- a. Requirements for Coverage. To be eligible for coverage as the Domestic Partner of a Subscriber, the following conditions must be met:
 - i. The individual must be eligible for coverage as a Domestic Partner as defined in Provision B.1.b.
 - ii. The Subscriber must elect coverage for his/her Domestic Partner.
 - iii. Premium payments must be made as required under this Evidence of Coverage.
- b. To be covered as a Dependent, a Domestic Partner must meet the eligibility requirements described herein. The Subscriber cannot cover or continue to cover his/her Domestic Partner if the Domestic Partnership does not meet the following requirements:
 - i. The Subscriber and the Domestic Partner are the same sex or opposite sex and both are at least eighteen (18) years of age and have the legal capacity to enter into a contract;
 - ii. The Subscriber and the Domestic Partner are not parties to a legally recognized marriage and are not in a civil union or domestic partnership with anyone else;
 - iii. The Subscriber and Domestic Partner are not related to the other by blood or marriage within four (4) degrees of consanguinity under civil law rule;
 - iv. The Subscriber and Domestic Partner share a common primary residence. The Subscriber must submit one (1) of the following documents as proof of a shared common primary residence:
 - a) Common ownership of the primary residence via joint deed or mortgage;
 - b) Common leasehold interest in the primary residence;
 - c) Driver's license or State-issued identification listing a common address; or,
 - d) Utility or other household bill with both the name of the Subscriber and the Domestic Partner appearing.
 - v. The Subscriber and Domestic Partner are Financially Interdependent and submit documentary evidence of their committed relationship of mutual interdependence, existing for at least six (6) consecutive months prior to application.

Financially Interdependent means the Subscriber and Domestic Partner can establish that they are in a committed relationship of mutual interdependence in which each individual contributes to some extent to the other individual's maintenance and support with the intention of remaining in the relationship indefinitely. Financial Interdependence can be established by submitting documentation from any one (1) of the following criteria:

- a) Joint bank account or credit account;
- b) Designation of one partner as the other's primary beneficiary with respect to life insurance or retirement benefits;
- c) Designation of one partner as the primary beneficiary under the other partner's will;
- d) Mutual assignments of valid durable powers of attorney under §13-601 of the Estates and Trusts Article of the Maryland Annotated Code, or the applicable laws of any state or the District of Columbia;
- e) Mutual valid written advanced directives under §5-601 of the Health-General Article of the Annotated Code of Maryland, or the applicable laws of any state or the District of Columbia, approving the other partner as health care agent;
- f) Joint ownership or holding of investments; or
- g) Joint ownership or lease of a motor vehicle.

2. **Eligibility of a Child of a Subscriber's Domestic Partner.** The child of the Subscriber's Domestic Partner is eligible for coverage as any other Dependent Child if the Domestic Partner meets the qualifications for coverage and the child of the Domestic Partner meets the eligibility requirements of a Dependent Child of a Domestic Partner.

Dependent Child of a Domestic Partner means an individual who:

- a. Is:
 - i. The natural child, stepchild, adopted child, or grandchild of the Subscriber's eligible Domestic Partner;
 - ii. A child (including a grandchild) placed with the Subscriber's eligible Domestic Partner for legal adoption; or
 - iii. An individual under testamentary or court appointed guardianship, other than temporary guardianship for less than twelve (12) months duration, of the Subscriber's eligible Domestic Partner.
- b. Has not provided over one-half of his/her own support for the previous calendar year.
- c. Is unmarried; and
- d. Is under the Limiting Age as stated in the Eligibility Schedule attached to this Evidence of Coverage; or
- e. Is a child who is the subject of a Medical Child Support Order that creates or recognizes the right of the child to receive benefits under the health insurance coverage of the Subscriber's covered Domestic Partner.

Children whose relationship to the Subscriber's Domestic Partner is not listed above, including, but not limited to foster children or children whose only relationship is one of legal guardianship (except as provided above) are not covered under this Evidence of Coverage, even though the child may live with the Subscriber's Domestic Partner and be dependent upon the Subscriber's Domestic Partner for support.

3. **Enrollment Opportunities.** The terms and conditions for the enrollment, including special and late enrollment (if applicable), of a Domestic Partner or the eligible child of a Domestic Partner under this Evidence of Coverage will be the same, respectively, as that of a Subscriber's spouse and the eligible child of a Subscriber's spouse.

First Eligibility Date for an eligible

- a. Domestic Partner shall be the date established by the Group's enrollment procedures.
- b. Child of a Domestic Partner shall be the same as that of the Domestic Partner, if the child meets the definition of a Dependent Child of a Domestic Partner, as set forth in the Evidence of Coverage. Otherwise, the First Eligibility Date for the child of a Domestic Partner will be the date on which the child first meets the definition of Dependent Child of a Domestic Partner, as stated in this rider.

SECTION C - CONTINUATION OF COVERAGE

The Evidence of Coverage is amended to include the following:

1. **Federal Continuation Coverage.** If your Group is subject to COBRA, continuation coverage under COBRA will be made available by the Group to a Domestic Partner and will be made available by the Group to a Dependent Child of a Domestic Partner. If your Group chooses to make COBRA continuation coverage available to a Domestic Partner and Dependent Child of a Domestic Partner, the terms and conditions of the continuation coverage will be the same as the terms and conditions of COBRA continuation coverage offered to a spouse and the Dependents of a spouse.
2. **Maryland Continuation Coverage.** The provisions in the Evidence of Coverage regarding Maryland continuation coverage are applicable to a Domestic Partner. The provisions in the Evidence of Coverage regarding Maryland continuation coverage are not applicable to the children of a Domestic Partner. The terms and conditions of the continuation coverage for a Domestic Partner will be the same as the terms and conditions of continuation coverage provided to a spouse.

SECTION D - CONVERSION PRIVILEGE

The Evidence of Coverage is amended to include the following:

1. Following the death of a Subscriber, the enrolled Domestic Partner, or if there is no Domestic Partner, the covered Dependent children may purchase a Conversion Contract.
2. If a Domestic Partner's coverage terminates due to a failure to continue to meet the eligibility requirements of a Domestic Partnership under the terms of this rider, the Domestic Partner is not entitled to purchase a Conversion Contract.

This rider is issued to be attached to the Evidence of Coverage.

CareFirst of Maryland, Inc.



Chester E. Burrell
President and Chief Executive Officer

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TERMINATION OF COVERAGE AMENDMENT

This amendment is effective as of the effective date of the Evidence of Coverage. Notwithstanding any provision or exclusion to the contrary, the Evidence of Coverage is amended as follows:

Section 4.1.E. entitled **Disenrollment of Individual Members** within **TERMINATION OF COVERAGE** is deleted and replaced with the following:

- E. Except in the case of a Dependent child enrolled pursuant to a Medical Child Support Order or Qualified Medical Support Order, the Dependents' coverage will terminate if the Subscriber changes the Type of Coverage to an Individual or other non-family contract.

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MEDICALLY NECESSARY AMENDMENT

This amendment is effective on the effective date of the Evidence of Coverage to which this amendment is attached.

The definition of "Medically Necessary or Medical Necessity" in the Evidence of Coverage is deleted and replaced with the following:

Medically Necessary or Medical Necessity means health care services or supplies that a Health Care Provider, exercising prudent clinical judgment, renders to or recommends for, a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms. These health care services or supplies are:

1. in accordance with generally accepted standards of medical practice;
2. clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for a patient's illness, injury or disease;
3. not primarily for the convenience of a patient or Health Care Provider; and
4. not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results in the diagnosis or treatment of that patient's illness, injury, or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations and views of Health Care Providers practicing in relevant clinical areas, and any other relevant factors.

This amendment is issued to be attached to the Group Contract and Evidence of Coverage. This amendment does not change the terms and conditions of the Group Contract and Evidence of Coverage, unless specifically stated herein.

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SPECIAL ENROLLMENT PERIODS AMENDMENT

This amendment is effective on the effective date of the Evidence of Coverage to which this amendment is attached.

The following is added to the Eligibility and Enrollment section, 2.6 Enrollment Opportunities and Effective Dates, C. Special Enrollment Periods:

c. Special enrollment regarding Medicaid and CHIP termination or eligibility:

CareFirst will permit an employee or dependent who is eligible for coverage, but not enrolled, to enroll for coverage under the terms of this Evidence of Coverage, if either of the following conditions is met:

- 1) The employee or dependent is covered under a Medicaid plan under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act and coverage of the employee or dependent under such a plan is terminated as a result of loss of eligibility for such coverage;
- 2) The employee or dependent becomes eligible for premium assistance, with respect to coverage under this Evidence of Coverage, under Medicaid or a State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan).

The following is added to the Eligibility Schedule section, SPECIAL ENROLLMENT PERIODS:

SPECIAL ENROLLMENT PERIODS	
Special enrollment regarding Medicaid and CHIP termination or eligibility	<p>The employee must notify the Group, and the Group must notify CareFirst no later than 60 days after the date the employee or dependent is terminated as a result of loss of eligibility for coverage under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act</p> <p>The employee must notify the Group, and the Group must notify CareFirst no later than 60 days after the date the employee or dependent is determined to be eligible for premium assistance, with respect to coverage under this Evidence of Coverage, under Medicaid or a State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan)</p> <p>A new Subscriber and/or his/her dependents are effective on the date coverage terminated as a result of loss of eligibility for coverage under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act; or, the date eligible for premium assistance with respect to coverage under this Evidence of Coverage, under Medicaid or a State child health plan</p>

This amendment is issued to be attached to the Evidence of Coverage. This amendment does not change the terms and conditions of the Evidence of Coverage, unless specifically stated herein.

CareFirst of Maryland, Inc.

A handwritten signature in cursive script that reads "Chester E. Burrell".

Chester E. Burrell
President and Chief Executive Officer

CareFirst of Maryland, Inc.
doing business as
CareFirst BlueCross BlueShield
10455 Mill Run Circle
Owings Mills, Maryland 21117-5559

A private not-for-profit health service plan incorporated in the State of Maryland

An independent licensee of the Blue Cross and Blue Shield Association

EXPANSION OF DEPENDENT COVERAGE AMENDMENT REVISED

This amendment is effective on the effective date of the Evidence of Coverage to which this amendment is attached.

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SECTION A – DEFINITION OF DEPENDENT CHILD

SECTION B – ELIGIBILITY

SECTION C – TERMINATION

The Evidence of Coverage is amended as follows:

A. DEFINITION OF DEPENDENT CHILD

For the purposes of this amendment, a Dependent child is a child who is:

1. The natural child, stepchild, adopted child of the Subscriber or the Subscriber's covered Spouse;
2. A child placed with the Subscriber or the Subscriber's covered Spouse for legal Adoption; or
3. A child under testamentary or court appointed guardianship, other than temporary guardianship for less than 12 months' duration, of the Subscriber or the Subscriber's covered Spouse;

All provisions of the Evidence of Coverage that define or describe the eligibility of a Dependent child who is described above for coverage under the Evidence of Coverage are revised to include a Dependent child described above who has not attained his or her 26th birthday notwithstanding the Dependent child's:

1. Financial dependency on an individual covered under the Evidence of Coverage;
2. Marital status;
3. Residency with an individual covered under the Evidence of Coverage;
4. Student status;
5. Employment;
6. Eligibility for other coverage; or
7. Satisfaction of any combination of the above factors.

The Evidence of Coverage states the eligibility requirements for grandchildren. Those provisions are not changed by this amendment.

B. ELIGIBILITY

All provisions of the Evidence of Coverage that state that the eligibility for coverage of a Dependent child described in Section A above is based on any factor other than the relationship between the Dependent child and an individual covered under the Evidence of Coverage are deleted.

All requirements that the Dependent child described in Section A above, prior to his or her 26th birthday, be financially dependent on an individual covered under the Evidence of Coverage, that the Dependent child share a residence with an individual covered under the Evidence of Coverage, that the Dependent child meet certain student status requirements, that the Dependent child be unmarried, that the Dependent child not be eligible for other coverage, or that the Dependent child not be employed, are deleted. Nothing in this amendment should be construed to amend any requirement related to the eligibility of a Dependent child age 26 and over or to alter any requirement related to the eligibility of a dependent grandchild.

The Evidence of Coverage states the eligibility requirements for grandchildren. Those provisions are not changed by this amendment.

C. TERMINATION

All provisions of the Evidence of Coverage that state that the coverage of a Dependent child described in Section A above will terminate when the Dependent child marries, ceases to be financially dependent on an individual covered under the Evidence of Coverage, ceases to share a residence with an individual covered under the Evidence of Coverage, ceases to be a full-time or part-time student, is eligible for other coverage, becomes employed full-time or part-time, or reaches the Dependent child's 25th birthday are deleted.

The Evidence of Coverage is amended to provide that the coverage of a Dependent child described in Section A above will terminate on the date the Dependent child reaches his or her 26th birthday or the age stated in the Eligibility Schedule, whichever is greater. The Limiting Age will not apply to a Dependent child described in Section A above, who at the time of reaching the Limiting Age, is incapable of self-support because of mental or physical incapacity that started before the Dependent child attained the Limiting Age, provided the incapacitated Dependent child is unmarried and dependent on an individual covered under the Evidence of Coverage. Coverage of the incapacitated Dependent child described in Section A above will continue for as long as the Dependent child remains incapable of self-support because of a mental or physical incapacity, unmarried, and dependent on an individual covered under the Evidence of Coverage.

The Evidence of Coverage states the Limiting Age and termination of coverage terms for grandchildren. Those provisions are not changed by this amendment.

This amendment is issued to be attached to the Evidence of Coverage. This amendment does not change the terms and conditions of the Evidence of Coverage, unless specifically stated herein.

CareFirst of Maryland, Inc.



Chester E. Burrell
President and Chief Executive Officer

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ATTACHMENT A

**BENEFIT DETERMINATION AND
APPEAL AND GRIEVANCE PROCEDURES**

This attachment contains certain terms that have a specific meaning as used herein. These terms are capitalized and defined in Section A below, and/or in the Evidence of Coverage to which this document is attached.

These procedures replace all prior procedures issued by the Plan, which afford Members recourse pertaining to denials and reductions of claims for benefits by the Plan.

These procedures only apply to Claims for Benefits. Notification required by these procedures will only be sent when a Member requests a benefit or files a claim in accordance with the Plan's procedures.

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- M. DEEMED EXHAUSTION OF INTERNAL CLAIMS AND APPEAL PROCESS**
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A. DEFINITIONS

The following terms shall have the meaning ascribed to such terms whenever such terms are used in these Claims Procedures.

Adverse Benefit Determination means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Member's eligibility to participate in a Plan, and including, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental/Investigational or not Medically Necessary or appropriate. An Adverse Benefit Determination also includes any Rescission of coverage (whether or not, in connection with the Rescission, there is an adverse effect on any particular benefit at that time).

Adverse Decision means a utilization review determination that:

1. A proposed or delivered health care service covered under the Member's contract is or was not Medically Necessary, appropriate, or efficient; and
2. May result in non-coverage of the health care service. Adverse Decision does not include a Coverage Decision.

Appeal means a protest filed by a Member, the Member's Representative or Health Care Provider acting on behalf of the Member with the Plan under its internal appeal process regarding a Coverage Decision.

Appeal Decision means final determination by the Plan that arises from an Appeal.

Claim for Benefits means a request for a Plan benefit or benefits made by a Member in accordance with a Plan's reasonable procedure for filing benefit claims. A Claim for Benefits includes any Pre-Service Claims and any Post-Service Claims.

Claim Involving Urgent Care means any claim for medical care or treatment that involves an Emergency Case or a Urgent Medical Condition. Whether a claim is a Claim Involving Urgent Care is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine; however, any claim that a physician with knowledge of the Member's medical condition determines is a Claim Involving Urgent Care shall be treated as a Claim Involving Urgent Care for purposes of these Claims Procedures.

Claims Procedures means, collectively, the procedures governing the filing of benefit claims, Notification of benefit determinations, and Grievances and Appeals of Adverse Benefit Determinations for Members.

Compelling Reason means a showing that the potential delay in receipt of a health care service until after the Member, the Member's Representative or Health Care provider acting on behalf of the Member exhausts the internal grievance process and obtains a final decision under the grievance process could result in loss of life, serious impairment to a bodily function, serious dysfunction of a bodily organ, or the Member remaining seriously mentally ill with symptoms that cause the Member to be in danger to self or others.

Complaint means a protest filed with the Maryland Insurance Commissioner involving an Adverse Benefit Determination, Appeal Decision or Grievance Decision.

Coverage Decision means:

1. An initial determination by the Plan or the Plan's Designee that results in non-coverage of a health care service;
2. An determination by the Plan that that an individual is not eligible for coverage under the Evidence of Coverage; or
3. A determination by the Plan that results in the Rescission of an individual's coverage under the Evidence of Coverage;

A Coverage Decision includes nonpayment of all or part of Claim for Benefits. A Coverage Decision does not include an Adverse Decision or a Pharmacy Inquiry.

Designee of the Commissioner means any person to whom the Commissioner has delegated the authority to review and decide Complaints, including an administrative law judge to whom the authority to conduct a hearing has been delegated for recommended or final decision.

Emergency Case means medical services are necessary to treat a condition or illness that, without immediate medical attention, would either (i) seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function, or (ii) cause the Member to be in danger to self or others.

Filing Date means the earlier of:

1. 5 days after the date of mailing; or
2. The date of receipt.

Grievance means a protest filed by a Member, the Member's Representative or Health Care Provider acting on behalf of the Member through the Plan's internal Grievance process regarding an Adverse Decision.

Grievance Decision means a final determination by the Plan that arises from a Grievance.

Group Health Plan means an employee welfare benefit Plan within the meaning of Section 3(1) of the Act to the extent that such Plan provides "medical care" within the meaning of Section 733(a) of the Employee Retirement and Income Security Act ("ERISA" or "Act").

Health Advocacy Unit means the Health Education and Advocacy Unit in the Division of Consumer Protection of the Office of the Attorney General established under Title 13, Subtitle 4A of the Commercial Law Article, Annotated Code of Maryland.

Health Care Provider, as used in this attachment, means:

1. An individual who is licensed under the Health Occupations Article, Annotated Code of Maryland, to provide health care services in the ordinary course of business or practice of a profession and is a treating provider of the Member; or
2. A hospital as defined in Title 19 Subtitle 3 of the Health-General Article.

Member, as used in this attachment, means an individual entitled to receive health care benefits under this Evidence of Coverage.

Member's Representative means an individual who has been authorized by a Member to file a Grievance, Appeal or a Complaint on behalf of a Member.

Notice or Notification means the delivery or furnishing of information to an individual in a manner appropriate with respect to material required to be furnished or made available to an individual.

Pharmacy Inquiry means an inquiry submitted by a pharmacist or pharmacy on behalf of a Member to the Plan, Plan Designee or pharmacy benefits manager at the point of sale about the scope of pharmacy coverage, pharmacy benefit design, or formulary under the Plan.

Plan means that portion of the Group Health Plan established by the Group that provides for health care benefits for which CareFirst e is the carrier under the Evidence of Coverage.

Plan Designee, for purposes of these Claims Procedures, means CareFirst.

Post-Service Claim means any claim for a benefit that is not a Pre-Service Claim.

Pre-Service Claim means any claim for a benefit with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

Relevant. A document, record, or other information shall be considered Relevant to a Member's claim if such document, record, or other information:

1. Was relied upon in making the benefit determination;
2. Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination;
3. Demonstrates compliance with the administrative processes and safeguards required pursuant to these Claims Procedures in making the benefit determination; or
4. Constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the Member's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Rescission means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to pay required premiums or contributions towards the cost of coverage.

Urgent Medical Condition means a condition that satisfies either of the following:

1. A medical condition, including a physical condition, a mental condition, or a dental condition, where the absence of medical attention within 72 hours could reasonably be expected by an individual, acting on behalf of the Plan, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, to result in:
 - a. Placing the member's life or health in serious jeopardy;
 - b. The inability of the member to regain maximum function;
 - c. Serious impairment to bodily function;
 - d. Serious dysfunction of any bodily organ or part; or
 - e. The member remaining seriously mentally ill with symptoms that cause the member to be a danger to self or others; or
2. A medical condition, including a physical condition, a mental health condition, or a dental condition, where the absence of medical attention within 72 hours in the opinion of a Health Care Provider with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the coverage decision.

B. SCOPE

The Plan's Claims Procedures were developed in accordance with Section 503 of the Employee Retirement Income Security Act of 1974 (ERISA or the Act), 29 U.S.C. 1133, 1135, which sets forth minimum requirements for employee benefit plan procedures pertaining to Claims For Benefits by Members.

C. CLAIMS PROCEDURES

These procedures govern the filing of benefit claims, Notification of benefit determinations, and Appeals and Grievances of Adverse Benefit Determinations (hereinafter collectively referred to as Claims Procedures) for Members.

These Claims Procedures do not preclude a Member's Representative or Health Care Provider acting on behalf of a Member from acting on behalf of such Member in pursuing a Claim for Benefits, Grievance or Appeal of an Adverse Benefit Determination, or a Complaint to the Maryland Insurance Commissioner. Nevertheless, the Plan has established reasonable procedures for determining whether an individual has been authorized to act on behalf of a Member.

These Claims Procedures contain administrative processes and safeguards designed to ensure and to verify that benefit claim determinations and Adverse Benefit Determinations are made in accordance with governing Plan documents and, where appropriate, Plan provisions have been applied consistently with respect to similarly situated Members.

D. CLAIMS PROCEDURES COMPLIANCE

1. Failure to follow Pre-Service Claims Procedures. In the case of a failure by a Member or a Member's Representative to follow the Plan's procedures for filing a Pre-Service Claim the Member or representative shall be notified of the failure and the proper procedures to be followed in filing a Claim for Benefits. This Notification shall be provided to the Member, the Member's Representative, or Health Care Provider acting on behalf of the Member, as appropriate, as soon as possible, but not later than 5 days (24 hours in the case of a failure to file a Claim Involving Urgent Care) following the failure. Notification may be oral, unless written Notification is requested by the Member, the Member's Representative or Health Care Provider acting on behalf of the Member.

The above shall apply only in the case of a failure that:

- a. Is a communication by a Member, the Member's Representative, or Health Care Provider acting on behalf of the Member that is received by the person or organizational unit designated by the Plan or Plan Designee that handles Claims for Benefits; and
 - b. Is a communication that names a specific Member; a specific medical condition or symptom; and a specific treatment, service, or product for which approval is requested.
2. Civil Action. A Member is not required to file more than the Appeals process described herein prior to bringing a civil action under ERISA.

E. TIMING OF NOTIFICATION OF ADVERSE BENEFIT DETERMINATIONS

1. In general. Except as provided in paragraph E.2 below, if a claim is wholly or partially denied, the Member shall be notified in accordance with paragraph F. herein, of the Adverse Benefit Determination within a reasonable period of time, but not later than 30 days after receipt of the claim by the Plan or the Plan's Designee, unless it is determined that special circumstances require an extension of time for processing the claim (for example, the legitimacy of the claim or the appropriate amount of reimbursement is in dispute and additional information is necessary to determine if all or part of the claim will be reimbursed and what specific additional information is necessary; or the claim is not clean and the specific information necessary for the claim to be considered a clean claim). If it is determined that an extension of time for processing is required, written Notice of the extension shall be furnished to the Member prior to the termination of the initial 30-day period. In no event shall such extension exceed a period of 30 days from the end of such initial period. The extension Notice shall indicate the special circumstances requiring an extension of time and the date by which the benefit determination will be rendered.

2. The Member shall be notified of the determination in accordance with the following, as appropriate.
 - a. Expedited Notification of benefit determinations relating to Claims Involving Urgent Care. In the case of a Claim Involving Urgent Care, the Member shall be notified of the benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim unless the Member fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Member shall be notified as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information necessary to complete the claim. The Member shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. Notification of any Adverse Benefit Determination pursuant to this paragraph shall be made in accordance with paragraph F. herein. The Member shall be notified of the benefit determination as soon as possible, but in no case later than 48 hours after the earlier of:
 - i. Receipt of the specified information, or
 - ii. The end of the period afforded the Member to provide the specified additional information.
 - b. Concurrent care decisions. If an ongoing course of treatment has been approved to be provided over a period of time or number of treatments:
 - i. Any reduction or termination of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments shall constitute an Adverse Benefit Determination. The Member shall be notified in accordance with paragraph E.2.e herein, of the Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow the Member to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated.
 - ii. Any request by a Member to extend the course of treatment beyond the period of time or number of treatments that is a Claim Involving Urgent Care shall be decided as soon as possible, taking into account the medical exigencies. The Member shall be notified of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim, provided that any such claim is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Notification of any Adverse Benefit Determination concerning a request to extend the course of treatment, whether involving urgent care or not, shall be made in accordance with paragraph F. herein, and an Appeal shall be governed by paragraphs G.2, G.3 and G.4 herein as appropriate.

- iii. If a health care service for a Member has been preauthorized or approved by the Plan or the Plan's Designee, the Plan may not deny reimbursement to the Health Care Provider for the preauthorized or approved service delivered to the Member unless:
 - 1) The information submitted regarding the service was fraudulent or intentionally misrepresentative;
 - 2) Critical information required by the Plan or the Plan's Designee was omitted such that the Plan or Plan Designee's determination would have been different had it known the critical information;
 - 3) A planned course of treatment for the Member was not substantially followed by the Health Care Provider; or
 - 4) On the date the preauthorized service was delivered:
 - a) the Member was not covered by the Plan;
 - b) the Plan or the Plan's Designee maintained an automated eligibility verification system that was available to the Provider by telephone or via the Internet; and
 - c) according to the verification system, the Claimant was not covered by the Plan.

iv. Continued coverage will be provided pending the outcome of an appeal.

c. Other claims for health care benefits. In the case of a claim that is not an urgent care claim or a concurrent care decision the Member shall be notified of the benefit determination in accordance with the below "Pre-Service Claims" or "Post-Service Claims," as appropriate.

i. Pre-Service Claims. In the case of a Pre-Service Claim, the Member shall be notified of the benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim. This period may be extended one time for up to 15 days, provided that the Plan or the Plan's Designee both determines that such an extension is necessary due to matters beyond its control, and notifies the Member, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered. If such an extension is necessary due to a failure of the Member to submit the information necessary to decide the claim, the Notice of extension shall specifically describe the required information, and the Member shall be afforded at least 45 days from receipt of the Notice within which to provide the specified information. Notification of any Adverse Benefit Determination pursuant to this paragraph shall be made in accordance with paragraph G. herein.

Authorization of Pre-Service Claims. The Plan or the Plan's Designee will determine whether to authorize or certify a Pre-Service Claim within 2 working days following receipt of all necessary information. If information is needed to make a decision which was not included in the initial request for authorization or certification, the Plan or the Plan's Designee will notify the Health Care Provider within 3 calendar days of the initial request that additional information is needed.

- ii. **Post-Service Claims.** In the case of a Post-Service Claim, the Member shall be notified, in accordance with paragraph G. herein, of the Adverse Benefit Determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time for up to 15 days, provided that the Plan or the Plan's Designee both determines that such an extension is necessary and notifies the Member, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered. If such an extension is necessary, the Plan or the Plan's Designee will send a Notice of receipt and status of the claim that states the legitimacy of the claim or the appropriate amount of reimbursement is in dispute and additional information is necessary to determine if all or part of the claim will be reimbursed and what specific additional information is necessary; or that the claim is not clean and the specific additional information necessary for the claim to be considered a clean claim. The Member shall be afforded at least 45 days from receipt of the Notice within which to provide the specified information.
- d. **Rescission determinations.** The Plan shall provide 30-days advance written Notice of any proposed Rescission of coverage for any individual.
- e. **Calculating time periods.** For purposes of paragraph E. herein the period of time within which a benefit determination is required to be made shall begin at the time a claim is filed, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended as permitted pursuant to paragraph E.2 above due to a Member's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the Notification of the extension is sent to the Member until the date on which the Member responds to the request for additional information.

F. MANNER AND CONTENT OF NOTIFICATION OF ADVERSE BENEFIT DETERMINATIONS

- 1. This section sets forth the manner and content of Notifications by the Plan of Adverse Benefit Determinations.
- 2. In the case of an Adverse Decision, the Plan or the Plan's Designee shall send a Member, the Member's Representative or Health Care Provider acting on behalf of the Member written or electronic Notification of any Adverse Benefit Determination. In the case of an Adverse Decision relating a Claim for Benefits that is not a Claim Involving Urgent Care, the Plan or the Plan's Designee shall send the written or electronic Notification within 5 working days after the Adverse Decision has been made. The Notification shall set forth, in a manner calculated to be understood by the Member, the Member's Representative or Health Care Provider:
 - a. The identity of the claim involved (including the date of service, the Health Care Provider and the claim amount (if applicable)).

- b. The specific reason or reasons for the Adverse Decision;
- c. Reference to the specific Plan provisions on which the Adverse Decision is based;
- d. A description of any additional material or information necessary for the Member, the Member's Representative or Health Care Provider acting on behalf of the Member to perfect the claim and an explanation of why such material or information is necessary;
- e. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Member's right to bring a civil action under Section 502(a) of the Act following an Adverse Decision;
- f. The Medical Director's name, business address and business telephone number;
- g. If an internal rule, guideline, protocol, diagnosis code, treatment code, or other similar criterion was relied upon in making the Adverse Decision, either (i) the specific rule, guideline, protocol, diagnosis code (and its corresponding meaning), treatment code (and its corresponding meaning) or other similar criterion; or (ii) a statement that such a rule, guideline, protocol, diagnosis code, treatment code, or other similar criterion was relied upon in making the Adverse Decision and that a copy of such rule, guideline, protocol, diagnosis code (and its corresponding meaning) or treatment code (and its corresponding meaning), or other criterion will be provided free of charge to the Member upon request; or
- h. If the Adverse Decision is based on a Medical Necessity or Experimental/Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Member's medical circumstances.
- i. In the case of an Adverse Decision by the Plan or the Plan's Designee concerning a Claim Involving Urgent Care, a description of the expedited review process applicable to such claims. This information may be provided orally to the Member, the Member's Representative or Health Care Provider acting on behalf of the Member within the timeframe prescribed in paragraph E.2. herein. The Member, the Member's Representative or Health Care Provider acting on behalf of the Member must be provided a written or electronic Notification no later than one (1) day after the oral Notification.

- j. That the Member, the Member's Representative or Health Care Provider acting on behalf of the Member has a right to file a Complaint with the Commissioner within 4 months after receipt of the Plan's Grievance Decision;
 - k. That a Complaint may be filed without first filing a Grievance if
 - i. The Plan notifies the Member in writing that it has waived the requirement that its internal grievance process be exhausted before filing a Complaint with the Commissioner;
 - ii. The Plan has failed to comply with any of the requirements of the internal grievance procedure described in this attachment; or
 - iii. the Member, the Member's Representative or Health Care Provider acting on behalf of the Member filing a Grievance on behalf of the Member can demonstrate a Compelling Reason to do so as determined by the Commissioner;
 - l. The Commissioner's address, telephone number, and facsimile number;
 - m. A statement that the Health Advocacy Unit is available to assist the Member, the Member's Representative or Health Care Provider acting on behalf of the Member in both mediating and filing a Grievance; and
 - n. The Health Advocacy Unit's address, telephone number, facsimile number, and electronic mail address.
3. In the case of a Coverage Decision, the Plan or the Plan Designee must within 30 calendar days provide Member, Member's Representative and the treating Health Care Provider, a written Notice of the Coverage Decision. The statement must state in detail, in clear, understandable language, the specific factual basis for the Plan's decision and must include the following information:
- a. Where applicable, the identity of the claim involved (including the date of service, the Health Care Provider and the claim amount).
 - b. The specific reason or reasons for the Coverage Decision;
 - c. Reference to the specific Plan provisions on which the Coverage Decision is based;
 - d. A description of any additional material or information necessary for the Member, the Member's Representative or Health Care Provider acting on behalf of the Member to perfect the claim and an explanation of why such material or information is necessary;
 - e. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Member's right to bring a civil action under Section 502(a) of the Act following a Coverage Decision;
 - f. That the Member, Member's Representative or Health Care Provider acting on behalf of the Member has a right to file an Appeal with the Plan or the Plan's Designee;

- g. In the case of a Coverage Decision by the Plan or the Plan's Designee concerning a Claim Involving Urgent Care, a description of the expedited review process applicable to such claims. This information may be provided orally to the Member, the Member's Representative or Health Care Provider acting on behalf of the Member within the timeframe prescribed in paragraph E.2. herein. The Member, the Member's Representative or Health Care Provider acting on behalf of the Member must be provided a written or electronic Notification no later than one (1) day after the oral Notification.
 - h. That the Member, the Member's Representative or Health Care Provider acting on behalf of the Member has a right to file a Complaint with the Commissioner within 4 months after receipt of the Plan's Appeal Decision;
 - i. That the Member, Member's Representative or Health Care Provider acting on behalf of the Member may file a Complaint with the Commissioner without first filing an Appeal, if the Coverage Decision involves a Claim Involving Urgent Care which has not been rendered;
 - j. The Commissioner's address, telephone number, and facsimile number;
 - k. A statement that the Health Advocacy Unit is available to assist the Member, the Member's Representative or Health Care Provider acting on behalf of the Member in both mediating and filing an Appeal; and
 - l. The Health Advocacy Unit's address, telephone number, facsimile number, and electronic mail address.
4. Adverse Benefit Determinations are made under the direction of the Medical Director.

G. APPEALS AND GRIEVANCES OF ADVERSE BENEFIT DETERMINATIONS

1. To file an Appeal or Grievance of an Adverse Benefit Determination, a Member, the Member's Representative or Health Care Provider acting on behalf of the Member, may contact the Plan at the address and telephone number located on the Member's ID Card; or submit a written request and any supporting record of medical documentation within 180 days of receipt of the written Notification of the Adverse Benefit Determination to the following:

Mail Administrator
P.O. Box 14114
Lexington, KY 40512-4114
410- 581-3000

The Health Advocacy Unit is available to assist the Member, the Member's Representative or Health Care Provider acting on behalf of the Member in both mediating and filing a Grievance or Appeal. See Section K for additional information.

- 2.
 - a. A Member has the opportunity to submit written comments, documents, records, and other information relating to the Claim for Benefits;
 - b. A Member shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant to the Member's Claim for Benefits;
 - c. The Plan or the Plan's Designee shall take into account all comments, documents, records, and other information submitted by the Member relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

3. In addition to the requirements of paragraphs G.2.a through c herein, the following apply:
 - a. The Plan or the Plan's Designee shall provide for a review that does not afford deference to the initial Adverse Benefit Determination and will be conducted by an individual who is neither the individual who made the Adverse Benefit Determination that is the subject of the Appeal or Grievance, nor the subordinate of such individual;
 - b. In deciding a Grievance of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental/Investigational, or not Medically Necessary or appropriate, the Plan or the Plan's Designee shall consult with a Health Care Provider with the same specialty as the treatment under review.
 - c. Upon request, the Plan or the Plan's Designee will identify medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Member's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination;
 - d. Health Care Provider engaged for purposes of a consultation under paragraph H.3.b herein shall be individuals who were neither consulted in connection with the Adverse Benefit Determination that is the subject of the Appeal or Grievance, nor subordinates of any such individuals; and
 - e. In the case of a Claim Involving Urgent Care, a request for an expedited Appeal or Grievance of an Adverse Benefit Determination may be submitted orally or in writing by the Member, the Member's Representative or Health Care Provider acting on behalf of the Member; and the Plan or the Plan's Designee must notify the Member, the Member's Representative or Health Care Provider acting on behalf of the Member of its determination in writing within 24 hours of receipt of the expedited request for Appeal or Grievance.
4. Full and fair review. The Plan or the Plan's Designee shall allow a Member, the Member's Representative or Health Care Provider acting on behalf of the Member to review the claim file and to present evidence and written testimony as part of the internal claims and Appeals or Grievances process. Specifically, in addition to the requirements of paragraphs G.2.a through c herein, the following apply:
 - a. The Plan or the Plan's Designee shall provide the Member, the Member's Representative or Health Care Provider acting on behalf of the Member, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan or the Plan's Designee (or at the direction of the Plan or the Plan's Designee) in connection with the claim; such evidence will be provided as soon as possible and sufficiently in advance of the date on which the Grievance Decision or Appeal decision is required to be provided under paragraph H. herein, to give the Member a reasonable opportunity to respond prior to that date; and
 - b. Before the Plan or the Plan's Designee issues a Grievance Decision or an Appeal Decision based on a new or additional rationale, the Member, the Member's Representative or Health Care Provider acting on behalf of the Member shall be provided, free of charge, with the rationale; the rationale shall be provided as soon as possible and sufficiently in advance of the date on which the Notice of Appeal Decision or Grievance Decision is required to be provided under paragraphs H and I. herein, to give the Member, the Member's Representative or Health Care Provider acting on behalf of the Member a reasonable opportunity to respond prior to that date.

H. TIMING OF NOTIFICATION OF ADVERSE BENEFIT DETERMINATIONS ON REVIEW (GRIEVANCE DECISIONS)

1. The Plan or the Plan's Designee shall notify a Member, the Member's Representative or Health Care Provider acting on behalf of the Member of its benefit determination on review of an Adverse Decision in accordance with the following, as appropriate.
 - a. Urgent care claims. In the case of a Claim Involving Urgent Care, the Member, the Member's Representative or Health Care Provider acting on behalf of the Member shall be notified, in accordance with paragraph J. herein, of the Grievance Decision as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the Member's request for review of an Adverse Decision. A written Notification must be provided to the Member, the Member's Representative or Health Care Provider acting on behalf of the Member within 24 hours of the orally communicated Grievance Decision.
 - b. Pre-service claims. In the case of a Pre-Service Claim, the Member, the Member's Representative or Health Care Provider acting on behalf of the Member shall be notified, in accordance with paragraph J herein, of the Grievance Decision within a reasonable period of time appropriate to the medical circumstances. Oral Notification shall be provided not later than 30 days after the filing date of the Member, the Member's Representative's or Health Care Provider's request for review of an Adverse Decision. A written Notification must be provided to the Member, the Member's Representative or Health Care Provider acting on behalf of the Member within 5 working days of the Grievance Decision.
 - c. Post-service claims. In the case of a Post-Service Claim, the Member, the Member's Representative or Health Care Provider acting on behalf of the Member shall be notified, in accordance with item J herein, of the Grievance Decision within a reasonable period of time. Oral Notification shall be provided not later than 45 working days after the filing date of the Member's, the Member's Representative's or Health Care Provider's request for review of an Adverse Decision. A written Notification must be provided to the Member, the Member's Representative or Health Care Provider acting on behalf of the Member within 5 working days of the Grievance Decision.
2. If the Plan or the Plan's Designee does not have sufficient information to complete its Grievance Decision, the Plan or the Plan's Designee must notify the Member, the Member's Representative or Health Care Provider acting on behalf of the Member within five (5) working days after the Filing Date of the Grievance by the Member, the Member's Representative or Health Care Provider acting on behalf of the Member with the Plan or the Plan's Designee. The Plan or the Plan's Designee Notification shall:
 - a. Notify the Member, the Member's Representative or Health Care Provider acting on behalf of the Member that it cannot proceed with reviewing the Grievance unless additional information is provided; and
 - b. Assist the Member, the Member's Representative or Health Care Provider acting on behalf of the Member in gathering the necessary information without further delay.

3. The Plan or the Plan's Designee may extend the 30-day or 45-working day period required for making an Grievance Decision under paragraph H.1.b., c. with the written consent of the Member, the Member's Representative or Health Care Provider acting on behalf of the Member who filed the Grievance on behalf of the Member. With the written consent of the Member, the Member's Representative or Health Care Provider acting on behalf of the Member who filed the Grievance on behalf of the Member, the Plan or the Plan's Designee may extend the period for making a final decision for an additional period of not longer than 30 working days. The Plan's extension request must describe the special circumstances necessitating the extension and the date on which the benefit determination will be made.
4. Calculating time periods. For purposes of Section H. herein, the period of time within which a Grievance Decision shall be made begins at the time a Grievance is received by the Plan or the Plan's Designee, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as permitted pursuant to paragraph H.2 herein due to a Member's, the Member's Representative's or Health Care Provider 's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the Notification of the extension is sent to the Member, the Member's Representative or Health Care Provider acting on behalf of the Member until the date on which the Member, the Member's Representative or Health Care Provider acting on behalf of the Member responds to the request for additional information.
5. In the case of Grievance, upon request, the Plan or the Plan's Designee shall provide such access to, and copies of Relevant documents, records, and other information described in paragraphs G.2, G.3, and G.4 herein as is appropriate.

I. TIMING OF NOTIFICATION OF ADVERSE BENEFIT DETERMINATIONS ON REVIEW (APPEAL DECISIONS)

1. The Plan or the Plan's Designee shall notify a Member, the Member's Representative or Health Care Provider acting on behalf of the Member of its Appeal Decision no later than 60 working days after the filing date of the Member, the Member's Representative 's or Health Care Provider's Appeal. A written Notification must be provided to the Member, the Member's Representative or Health Care Provider acting on behalf of the Member within 30 days of the Appeal Decision.
2. The Plan or the Plan's Designee may extend the 60-working day period required for making an Appeal Decision under I.1 with the written consent of the Member, the Member's Representative or Health Care Provider acting on behalf of the Member who filed the Appeal on behalf of the Member. With the written consent of the Member, the Member's Representative or Health Care Provider acting on behalf of the Member who filed the Appeal on behalf of the Member, the Plan or the Plan's Designee may extend the period for making a final decision for an additional period of not longer than 30 working days. The Plan's extension request must describe the special circumstances necessitating the extension and the date on which the benefit determination will be made.
3. Calculating time periods. For purposes of Section I. herein, the 60-working day period within which a benefit determination on review shall be made, subject to any extension granted pursuant to paragraph I.2 above, begins at the time an Appeal is received by the Plan or the Plan's Designee, without regard to whether all the information necessary to make an Appeal Decision accompanies the filing.

J. MANNER AND CONTENT OF NOTIFICATION OF GRIEVANCE DECISION OR APPEAL DECISION

The Plan or the Plan's Designee shall provide a Member, the Member's Representative or Health Care Provider acting on behalf of the Member with written or electronic Notification after it has provided oral communication of the Grievance Decision or Appeal Decision. The Notification shall set forth, in a manner calculated to be understood by the Member, the Member's Representative or Health Care Provider acting on behalf of the Member:

1. The identity of the claim involved (including the date of service, the Health Care Provider and the claim amount (if applicable)).
2. The specific factual basis for the adverse determination;
3. Reference to the specific criteria and standards, including interpretive guidelines, on which the benefit determination is based;
4. A statement that the Member is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant to the Member's Claim For Benefits;
5. A statement describing any voluntary Appeal or Grievance procedures offered by the Plan and the Member's right to obtain the information about such procedures, and a statement of the Member's right to bring an action under Section 502(a) of the Act; and
6.
 - a. If an internal rule, guideline, protocol, diagnosis code, treatment code, or other similar criterion was relied upon in making the adverse determination, either (i) the specific rule, guideline, protocol, diagnosis code (and its corresponding meaning), treatment code (and its corresponding meaning) or other similar criterion; or (ii) a statement that such a rule, guideline, protocol, diagnosis code, treatment code, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, diagnosis code (and its corresponding meaning) or treatment code (and its corresponding meaning), or other criterion will be provided free of charge to the Member upon request; or;
 - b. If the Adverse Benefit Determination is based on a Medical Necessity or Experimental/Investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Member's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
 - c. You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available it so contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

7. In the case of a Grievance involving an Adverse Decision, a statement that includes the following information:
 - a. The name, business address and business telephone number of the Medical Director who made the decision;
 - b. That the Member, the Member's Representative or Health Care Provider acting on behalf of the Member has a right to file a Complaint with the Commissioner within 4 months after receipt of the Grievance Decision;
 - c. The Commissioner's address, telephone number, and facsimile number;
 - d. A statement that the Health Advocacy Unit is available to assist the Member, the Member's Representative or Health Care Provider acting on behalf of the Member with filing a Complaint with the Commissioner;
 - e. The Health Advocacy Unit's address, telephone number, facsimile number and electronic mailing address;
 - f. The Employee Benefit Security Administration's telephone number and website address; and
 - g. A Notice that, when filing a Complaint with the Commissioner, the Member or a legally authorized designee of the Member will be required to authorize the release of any medical records of the Member that may be required to be reviewed for the purpose of reaching a decision on the Complaint.
8. In the case of an Appeal involving a Coverage Decision, a statement that includes the following information:
 - a. That the Member, the Member's Representative or Health Care Provider acting on behalf of the Member has a right to file a Complaint with the Commissioner within 4 months after receipt of the Appeal Decision; and
 - b. The Commissioner's address, telephone number, and facsimile number;
 - c. The Employee Benefit Security Administration's telephone number and website address; and
 - d. A statement that the Health Advocacy Unit is available to assist the Member, the Member's Representative or Health Care Provider acting on behalf of the Member with filing a Complaint with the Commissioner;
 - e. The Health Advocacy Unit's address, telephone number, facsimile number and electronic mailing address; and
 - f. A Notice that, when filing a Complaint with the Commissioner, the Member or a legally authorized designee of the Member will be required to authorize the release of any medical records of the Member that may be required to be reviewed for the purpose of reaching a decision on the Complaint.
9. Grievance Decisions and Appeal Decisions are made under the direction of the Chief Medical Officer:

1501 S. Clinton Street
Baltimore, Maryland 21224
410- 581-3000

K. FILING OF COMPLAINT AFTER RECEIPT OF NOTIFICATION OF GRIEVANCE DECISIONS OR APPEAL DECISIONS

1. Within 4 months after the date of receipt of an Appeal Decision or a Grievance Decision, a Member, the Member's Representative or Health Care Provider acting on behalf of the Member may file a Complaint with the Commissioner for review of the Grievance Decision or Appeal Decision.
2. A Member, the Member's Representative or Health Care Provider acting on behalf of the Member may file a Complaint without first exhausting the Plan's internal Grievance or Appeals process if:
 - a. In the case of an Adverse Decision:
 - i. The Plan or the Plan's Designee waives the requirement that the internal Grievance process be exhausted before filing a Complaint with the Commissioner;
 - ii. The Plan or the Plan's Designee has failed to comply with any of the requirements of the internal Grievance process;
 - iii. The Member, the Member's Representative or Health Care Provider acting on behalf of the Member provides sufficient information and supporting documentation in the Complaint to demonstrate a Compelling Reason.
 - b. In the case of a Coverage Decision, the Complaint involves an Urgent Medical Condition for which care has not been rendered.
3. The remaining provisions of this paragraph K. apply to Complaints regarding Adverse Decisions and Grievance Decisions.
 - a. The Commissioner shall notify the Plan or the Plan's Designee of the Complaint within five working days after the date the Complaint is filed with the Commissioner.
 - b. Except for an Emergency Case (Claim Involving Urgent Care), the Plan or the Plan's Designee shall provide to the Commissioner any information requested by the Commissioner no later than seven working days from the date the Plan or the Plan's Designee receives the request for information.
4. a. Except as provided in paragraph K.4.b below, the Commissioner shall make a final decision on a Complaint:
 - i. Within 45 days after a Complaint is filed regarding a Pre-Service Claim;
 - ii. Within 45 days after a Complaint is filed regarding a Post-Service Claim; and
 - iii. Within 24 hours after a Complaint is filed regarding a Claim Involving Urgent Care.

Note: the Health Advocacy Unit is available to assist the Member, the Member's Representative or Health Care Provider acting on behalf of the Member in both mediating and filing a Grievance. Contact the Health Advocacy Unit at:

Health Education and Advocacy Unit
Consumer Protection Division
Office of the Attorney General
200 St. Paul Place, 16th Floor
Baltimore, MD 21202
410- 528-1840 or 1-877- 261-8807
Fax: 410- 576-6571
E-mail: heau@oag.state.md.us

L. MEMBER COMMENTS AND QUALITY COMPLAINTS

The Plan provides Members an opportunity to present comments or any other questions or concerns with regard to operations or administration of the Plan, and file a quality complaint regarding the quality of any Plan service. All comments and quality complaints should be addressed to the Member Services Department. In the event that you are dissatisfied with a determination of the Member Services Department, the procedures listed below must be followed.

Inquiries, comments, and complaints concerning the nature of your medical care should also be addressed to the Member Services Department. That department will also assist you in filing a quality complaint after all other avenues of resolution have been exhausted.

A Member may complain to the Department of Health and Mental Hygiene, Office of Licensing and Certification Programs regarding the operation of The Plan. The address and telephone number of the Department is available through our Member Services Department. The Member may also contact the Maryland Insurance Administration at:

Maryland Insurance Administration
Inquiry and Investigation, Life and Health
200 St. Paul Place
Suite 2700
Baltimore, MD 21202-2272
410-468-2244

M. DEEMED EXHAUSTION OF INTERNAL CLAIMS AND APPEAL PROCESS

If the Plan fails to adhere to the minimum requirements for Claims Procedures relating to Claims for Benefits by Members or Section 15-10A-02 of the Insurance Code, Annotated Code of Maryland, the Member is deemed to have exhausted the internal appeals and grievance processes of paragraph G through J herein. Accordingly the Member may initiate an external review under paragraph K of this section, as applicable. The Member is also entitled, where applicable, to pursue any available remedies under section 502(a) of ERISA or under State law, as applicable, on the basis that the Plan has failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the Claim for Benefits. If a Member, where applicable, chooses to pursue remedies under section 502(a) of ERISA under such circumstances, the Claim for Benefits, Grievance, or Appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

N. MISCELLANEOUS

The Group reserves the right to change, modify, or terminate the Plan, in whole or in part.

Members have no Plan benefits after a Plan termination or partial Plan termination affecting them, except with respect to covered events giving rise to benefits and occurring prior to the date of Plan termination or partial Plan termination affecting them and except as otherwise expressly provided, in writing, by the Group, or as required by federal, state or local law.

CareFirst of Maryland, Inc.
 doing business as
 CareFirst BlueCross BlueShield
 10455 Mill Run Circle
 Owings Mills, Maryland 21117-5559

A private not-for-profit health service plan incorporated in the State of Maryland

An independent licensee of the BlueCross and BlueShield Association

COMPENSATION AND PREMIUM DISCLOSURE STATEMENT

Our compensation to providers who offer health care services and behavioral health care services to our insured members or enrollees may be based on a variety of payment mechanisms such as fee-for-service payments, salary, or capitation. Bonuses may be used with these various types of payment methods.

If you desire additional information about our methods of paying providers, or if you want to know which method(s) apply to your physician, please call our Member Services Department at the number listed on your identification card, or write to:

CareFirst of Maryland, Inc.
 doing business as CareFirst BlueCross BlueShield
 10455 Mill Run Circle
 Owings Mills, MD 21117-5559
 Attention: Member Services

A. METHODS OF PAYING PHYSICIANS

This table shows definitions of how insurance carriers may pay physicians (or other providers) for your health care services with a simple example of how each payment mechanism works.	
Terms	The example shows how Dr. Jones, an obstetrician gynecologist, would be compensated under each method of payment.
Salary	<p>A physician (or other provider) is an employee of the HMO and is paid compensation (monetary wages) for providing specific health care services.</p> <p>Since Dr. Jones is an employee of an HMO, she receives her usual bi-weekly salary regardless of how many patients she sees or the number of services she provides. During the months of providing pre-natal care to Mrs. Smith, who is a member of the HMO, Dr. Jones' salary is unchanged. Although Mrs. Smith's baby is delivered by Cesarean section, a more complicated procedure than a vaginal delivery, the method of delivery will not have an effect upon Dr. Jones' salary.</p>
Capitation	<p>A physician (or group of physicians) is paid a fixed amount of money per month by an HMO for each patient who chooses the physician(s) to be his or her doctor. Payment is fixed without regard to the volume of services that an individual patient requires.</p> <p>Under this type of contractual arrangement, Dr. Jones participates in an HMO network. She is not employed by the HMO. Her contract with the HMO stipulates that she is paid a certain amount each month for patients who select her as their doctor. Since Mrs. Smith is a member of the HMO, Dr. Jones monthly payment does not change as a result of her providing ongoing care to Mrs. Smith. The capitation amount paid to Dr. Jones is the same whether or not Mrs. Smith requires obstetric services.</p>

<p>This table shows definitions of how insurance carriers may pay physicians (or other providers) for your health care services with a simple example of how each payment mechanism works.</p>	
<p>Fee-for- Service</p>	<p>A physician (or other provider) charges a fee for each patient visit, medical procedure, or medical service provided. An HMO pays the entire fee for physicians it has under contract and an insurer pays all or part of that fee, depending on the type of coverage. The patient is expected to pay the remainder.</p> <p>Dr. Jones' contract with the insurer or HMO states that Dr. Jones will be paid a fee for each patient visit and each service she provides. The amount of payment Dr. Jones receives will depend upon the number, types, and complexity of services, and the time she spends providing services to Mrs. Smith. Because Cesarean deliveries are more complicated than vaginal deliveries, Dr. Jones is paid more to deliver Mrs. Smith's baby than she would be paid for a vaginal delivery. Mrs. Smith may be responsible for paying some portion of Dr. Jones' bill.</p>
<p>Discounted Fee-for-Service</p>	<p>Payment is less than the rate usually received by the physician (or other provider) for each patient visit, medical procedure, or service. This arrangement is the result of an agreement between the payer, who gets lower costs and the physician (or other provider), who usually gets an increased volume of patients.</p> <p>Like fee-for-service, this type of contractual arrangement involves the insurer or HMO paying Dr. Jones for each patient visit and each delivery; but under this arrangement, the rate, agreed upon in advance, is less than Dr. Jones' usual fee. Dr. Jones expects that in exchange for agreeing to accept a reduced rate, she will serve a certain number of patients. For each procedure that she performs, Dr. Jones will be paid a discounted rate by the insurer or HMO.</p>
<p>Bonus</p>	<p>A physician (or other provider) is paid an additional amount over what he or she is paid under salary, capitation, fee-for-service, or other type of payment arrangement. Bonuses may be based on many factors, including member satisfaction, quality of care, control of costs and use of services.</p> <p>An HMO rewards its physician staff or contracted physicians who have demonstrated higher than average quality and productivity. Because Dr. Jones has delivered so many babies and she has been rated highly by her patients and fellow physicians, Dr. Jones will receive a monetary award in addition to her usual payment.</p>
<p>Case Rate</p>	<p>The HMO or insurer and the physician (or other provider) agree in advance that payment will cover a combination of services provided by both the physician (or other provider) and the hospital for an episode of care.</p> <p>This type of arrangement stipulates how much an insurer or HMO will pay for a patient's obstetric services. All office visits for prenatal and postnatal care, as well as the delivery, and hospital-related charges are covered by one fee. Dr. Jones, the hospital, and other providers (such as an anesthesiologist) will divide payment from the insurer or HMO for the care provided to Mrs. Smith.</p>

B. PERCENTAGE OF PROVIDER PAYMENT METHODS

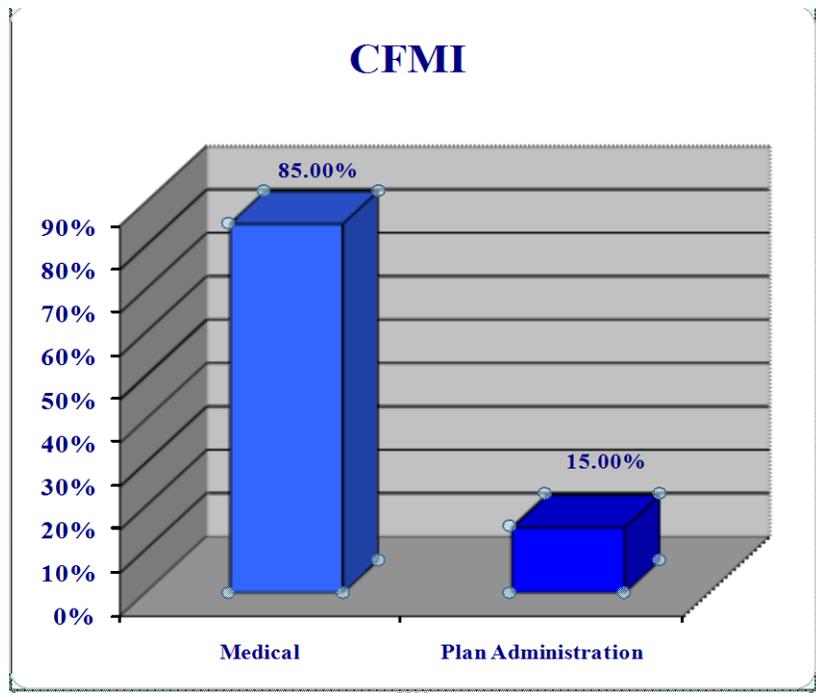
For its Indemnity and Preferred Provider Organization (PPO) products, CareFirst of Maryland, Inc. contracts directly with physicians. All physicians are reimbursed on a discounted fee-for-service basis.

C. DISTRIBUTION OF PREMIUM DOLLARS

The bar graph below illustrates the proportion of every \$100 in premium used by CareFirst of Maryland, Inc. to pay providers for medical care expenses, and the proportion used to pay for plan administration.

These numbers represent an average for all indemnity accounts based on our annual statement. The ratio of direct medical care expenses to plan administration will vary by account.

The composite distribution presented in this disclosure is presented pursuant to the requirements of Maryland law, and may differ from calculations of federal medical loss ratio for a carrier in a particular market under the requirements of the Patient Protection and Affordable Care Act, based on accounting differences in the formulae used.



When you have questions about your CareFirst benefits, feel free to call or write CareFirst BlueCross BlueShield.

Main Office

National Accounts Dedicated Service

Mail Administrator

P.O. Box 14114

Lexington, KY 40512-4114