Group Hospitalization and Medical Services, Inc.
doing business as
CareFirst BlueCross BlueShield (CareFirst)
[840 First Street, NE]
[Washington, DC 20065]
[202-479-8000]

An independent licensee of the Blue Cross and Blue Shield Association

ATTACHMENT [B]
[OUT-OF-NETWORK] DESCRIPTION OF COVERED SERVICES

The services described herein are eligible for coverage under the [Out-of-Network] [Evidence of Coverage; Agreement]. CareFirst will provide the benefits described in the [Out-of-Network] Schedule of Benefits for Medically Necessary Covered Services incurred by a Member.

It is important to refer to the [Out-of-Network] 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 [Out-of-Network] Schedule of Benefits also lists important information about Deductibles, the Out-of- Pocket Maximum, and other features that affect Member coverage, including specific benefit limitations.

Refer to the [Out-of-Network] [Evidence of Coverage; Agreement] for additional definitions of capitalized terms included in this Description of Covered Services.

Group Hospitalization and Medical Services, Inc.

[Signature]

_____

[Name]
[Title]

SECTION 1
OUTPATIENT FACILITY, OFFICE, AND PROFESSIONAL SERVICES

See Section 15, Utilization Management, for Covered Services that require prior authorization.

1.1 Office Visits
Benefits are available for office visits for the diagnosis and treatment of a medical condition, including care and consultation provided by primary care providers and Specialists.

1.2 Laboratory Tests, Radiologic Imaging, and Diagnostic Procedures. Coverage is provided for laboratory tests, radiologic imaging (X-rays, CAT Scans, MRIs, MRAs, etc.), and diagnostic procedures.

1.3 Preventive Services
In addition to the benefits listed in this provision, CareFirst will provide benefits for health exams and other services for the prevention and detection of disease, at intervals appropriate to the Member's age, sex, and health status, in accordance with the Patient Protection and Affordable Care Act, as amended, and the Health Care and Education Reconciliation Act of 2010, as amended, as well as CareFirst preventive guidelines. At a minimum, benefits for preventive services listed in this provision will be provided once per Benefit Period.

Benefits will be provided for evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF). This includes benefits for preventive maternity care. CareFirst will update new recommendations to the preventive benefits listed in this provision at the schedule established by the Secretary of Health and Human Services.

Benefits for preventive care include the following:

A. Cancer Screening Services
Benefits include:

1. Prostate Cancer Screening
Benefits are available when rendered in accordance with the most current American Cancer Society's guidelines and include a medically recognized diagnostic examination, annual digital rectal examinations, and the prostate-specific antigen (PSA) tests.

2. Colorectal Cancer Screening
Colorectal cancer screening provided in accordance with the latest guidelines issued by the American Cancer Society.

3. Pap Smears
Benefits are available for pap smears, including tests performed using FDA approved gynecological cytology screening technologies, at intervals appropriate to the Member's age and health status, as determined by CareFirst.

4. Breast Cancer Screening
At a minimum, benefits will be provided for breast cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society. The current recommendations of the United States Preventive Services Task Force regarding breast cancer screening, mammography, and prevention of breast cancer will be considered the most current other than those issued in or around November 2009.

B. Human Papillomavirus Screening Test

1. Coverage is provided for a Human Papillomavirus Screening Test at the screening intervals supported by the Health Resources and Services Administration of the U.S. Department of Health and Human Services.

2. Human Papillomavirus Screening Test means any laboratory test that specifically detects for infection by one or more agents of the human papillomavirus and is approved for this purpose by the FDA.

C. Immunizations

Coverage is provided for immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved. Immunizations required solely for travel or work are not covered.

A recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered to be:

1. In effect after it has been adopted by the Director of the Centers for Disease Control and Prevention; and

2. For routine use if it is listed on the immunization schedules of the Centers for Disease Control and Prevention.

D. Well Child Care

With respect to infants, children, and adolescents, coverage is provided for evidence-informed preventive care and screenings in the Recommendations for Preventive Pediatric Health by the American Academy of Pediatrics and the Recommended Uniform Screening Panels by the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children.

E. Adult Preventive Care

Benefits include health care services incidental to and rendered during an annual visit at intervals appropriate to the Member's age, sex , and health status, including evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF).

F. Preventive Gynecological Care

Benefits include recommended preventive services that are age and developmentally appropriate as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

G. Prevention and Treatment of Obesity

Benefits will be provided for:

1. Well child care visits for obesity evaluation and management;

2. Evidence-based items or services for preventive care and screening for obesity that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF);

3. For infants, children, and adolescents, evidence-informed preventive care and screening for obesity provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and,

4. Office visits for the treatment of childhood obesity.

5. Limitations

Benefits for the treatment of obesity are limited to Members under age nineteen (19). Benefits for preventive care and screening for obesity are available to all Members.

H. Osteoporosis Prevention and Treatment Services

1. Definitions

Bone Mass Measurement means a radiologic or other scientifically proven technology for the purpose of identifying bone mass or detecting bone loss.

Qualified Individual means a Member:

a. Who is estrogen deficient and at clinical risk for osteoporosis;

b. With a specific sign suggestive of spinal osteoporosis, including roentgenographic osteopenia or roentgenographic evidence suggestive of collapse, wedging, or ballooning of one or more thoracic or lumbar vertebral bodies, who is a candidate for therapeutic intervention or for an extensive diagnostic evaluation for metabolic bone disease;

c. Receiving long-term glucocorticoid (steroid) therapy;

d. With primary hyperparathyroidism; or,

e. Being monitored to assess the response to, or efficacy of, an approved osteoporosis drug therapy.

2. Covered Benefits

Benefits for Bone Mass Measurement for the prevention, diagnosis, and treatment of osteoporosis are covered when requested by a Health Care Provider for a Qualified Individual.

1.4 Professional Nutritional Counseling and Medical Nutrition Therapy

Benefits are available for Medically Necessary Professional Nutritional Counseling and Medical Nutrition Therapy as determined by CareFirst.

1.5 Family Planning Services

Benefits will be provided for:

A. Non-Preventive Gynecological Care

Benefits are available for Medically Necessary gynecological care. Benefits for preventive gynecological care are described in Section 1.3.F.

B. Contraceptive Methods and Counseling

Covered Benefits:

1. Contraceptive patient education and counseling for all Members with reproductive capacity.

2. Benefits will be provided for all FDA approved contraceptive drugs and devices for all Members, and sterilization procedures and other contraceptive methods for female Members that must be administered to the Member in the course of a covered outpatient or inpatient treatment.

3. Coverage will be provided for the insertion or removal, and any Medically Necessary examination associated with the use of any contraceptive devices or drugs that are approved by the FDA.

4. Voluntary sterilization for male Members and surgical reversal of voluntary sterilization for all members.

5. Elective abortion. [Pursuant to Section 1303(b)(1)(A) of the Affordable Care Act, if the Member receives federal premium subsidies for the purchase of this Agreement, the Member will be responsible for all charges for abortion services.]

See Section 11, Prescription Drugs, for coverage for self-administered FDA-approved contraceptive drugs and devices.

C. Maternity Services
The following maternity services are provided for all female members.

1. Preventive Services

a) Routine outpatient obstetrical care of an uncomplicated pregnancy, including prenatal evaluation and management office visits and one post-partum office visit;

b) Prenatal laboratory tests and diagnostic services related to the outpatient care of an uncomplicated pregnancy, including those identified in the current recommendations of the United States Preventive Services Task Force that have in effect a rating of "A" or "B" or provided in the comprehensive guidelines for women's preventive health supported by the Health Resources and Services Administration;

c) Preventive laboratory tests and services rendered to a newborn during a covered hospitalization for delivery, identified in the current recommendations of the United States Preventive Services Task Force that have in effect a rating of "A" or "B," the Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care, and the Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, including the collection of adequate samples for hereditary and metabolic newborn screening and newborn hearing screening; and

d) Breastfeeding support, supplies, and consultation.

e) These services, except for breastfeeding equipment, are covered to the same extent as other preventive services.

2. Non-Preventive Services

a) Outpatient obstetrical care and professional services for all prenatal and post-partum complications. Services include prenatal and post-partum office visits and Ancillary Services provided during those visits, such as Medically Necessary laboratory tests and diagnostic services;

b) Inpatient care for delivery;

c) Non-preventive routine professional services rendered to the newborn during a covered hospitalization for delivery. Non-routine care of the newborn, either during or following the mother's covered hospitalization, requires that the newborn be covered as a Member in the newborn's own right. The [Out-of-Network] [Evidence of Coverage; Agreement] describes the steps, if any, necessary to enroll a newborn Dependent

child.

3. Postpartum Home Visits. See Section 7.3.C., Home Health Care Services.

D. Newborn Coverage. Coverage includes:

1. Medically Necessary routine newborn visits including admission and discharge exams and visits for the collection of adequate samples for hereditary and metabolic newborn screening;

2. Medically Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities; and

3. Routine hearing screening consisting of one of the following:

a. Auditory brain stem response;

b. Otoacustic emissions; or

c. Other appropriate, nationally recognized, objective physiological screening test.

Additionally, benefits will be provided for infant hearing screenings and all necessary audiological examinations provided using any technology approved by the United States Food and Drug Administration, and as recommended by the most current standards addressing early hearing detection and intervention programs by the National Joint Committee on Infant Hearing. Such coverage will include follow-up audiological examinations as recommended by a physician or audiologist and performed by a licensed audiologist to confirm the existence or absence of hearing loss. Infant as used here is defined according to the most current recommendation of the American Academy of Pediatrics.

E. Infertility Services
Benefits are available for the diagnosis of infertility. Benefits are limited to the following:

A. Infertility counseling; and

B. Testing.

1.6 Allergy Services
Benefits are available for allergy testing and treatment, including allergy serum and the administration of injections.

1.7 Rehabilitation Services
A. Definitions

Physical Therapy (PT) includes the short-term treatment that can be expected to result in a significant improvement of a condition. Physical Therapy is the treatment of disease or injury through the use of therapeutic exercise and other interventions that focus on improving a person's ability to go through the functional activities of daily living, to develop and/or restore maximum potential function, and to reduce disability following an illness, injury, or loss of a body part. These may include improving posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility, and alleviating pain.

Occupational Therapy (OT) means the use of purposeful activity or interventions designed to achieve functional outcomes that promote health, prevent injury or disability, and that develop, improve, sustain or restore the highest possible level of independence of an individual who has an injury, illness, cognitive impairment, psychosocial dysfunction,

mental illness, developmental or learning disability, physical disability, loss of a body part, or other disorder or condition. Occupational Therapy services do not include the adjustment or manipulation of any of the osseous structures of the body or spine.

Speech Therapy (ST) means the treatment of communication impairment and swallowing disorders. Speech Therapy services facilitate the development and maintenance of human communication and swallowing through assessment, diagnosis, and rehabilitation, including cognitive rehabilitation.

B. Covered Benefits
Coverage includes benefits for rehabilitation services including Physical Therapy, Occupational Therapy, and Speech Therapy for the treatment of individuals who have sustained an illness or injury that CareFirst determines to be subject to improvement.

The goal of rehabilitation services is to return the individual to his/her prior skill and functional level.

1.8 Spinal Manipulation

A. Covered Services
Coverage is provided for Medically Necessary spinal manipulation, evaluation, and treatment for the musculoskeletal conditions of the spine when provided by a licensed chiropractor, doctor of osteopathy (D.O.), or other eligible practitioner.

B. Limitations. Benefits will not be provided for spinal manipulation services other than for musculoskeletal conditions of the spine.

1.9 Habilitative Services

Coverage includes Medically Necessary Habilitative services that help a Member keep, learn, or improve skills and functioning for daily living, including, but not limited to, applied behavioral analysis for the treatment of autism spectrum disorder.

1.10 Outpatient Therapeutic Treatment Services

Benefits are available for outpatient services rendered in a health care provider's office, in the outpatient department of a hospital, in an ambulatory surgical facility, or other outpatient facility in connection with a medical or surgical procedure covered under Section 1, Outpatient Facility, Office, and Professional Services. Benefits include services and treatments such as:

A. Hemodialysis and peritoneal dialysis;

B. Chemotherapy;

C. Radiation therapy, including oncology dialysis;

D. Cardiac Rehabilitation benefits are provided to Members who have been diagnosed with significant cardiac disease, as defined by CareFirst, or, who have suffered a myocardial infarction or have undergone invasive cardiac treatment immediately preceding recommendation for Cardiac Rehabilitation, as defined by CareFirst. Coverage is provided for all Medically Necessary services, as determined by CareFirst. Services must be provided at a CareFirst approved place of service equipped and approved to provide Cardiac Rehabilitation.

E. Pulmonary Rehabilitation benefits are provided to Members who have been diagnosed with significant pulmonary disease, as defined by CareFirst, or, who have undergone certain surgical procedures of the lung, as defined by CareFirst. Coverage is provided for all Medically Necessary services, as determined by CareFirst. Services must be provided at a CareFirst approved place of service equipped and approved to provide pulmonary rehabilitation.

F. Infusion and transfusion services;

G. Electroshock therapy; and

H. Radioisotope treatment.

1.11 Blood and Blood Products
Benefits are available for blood and blood products (including derivatives and components) that are not replaced by or on behalf of the Member.

1.12 Organ and Tissue Transplants

A. Coverage is provided for all Medically Necessary, non-Experimental/Investigational bone marrow, solid organ transplant, and other non-solid organ transplant procedures. Medical Necessity is determined by CareFirst.

B. Covered Services include the following:

1. The expenses related to registration at transplant facilities. The place of registry is subject to review and determination by CareFirst.

2. Organ procurement charges including harvesting, recovery, preservation, and transportation of the donated organ.

3. Cost of hotel lodging and air transportation for the recipient Member and a companion (or the recipient Member and two companions if the recipient Member is under the age of eighteen (18) years) to and from the site of the transplant.

4. There is no limit on the number of re-transplants that are covered.

5. If the Member is the recipient of a covered organ/tissue transplant, CareFirst will cover the Donor Services (as defined below) to the extent that the services are not covered under any other health insurance plan or contract.

Donor Services means services covered under the [Out-of-Network] [Evidence of Coverage; Agreement] which are related to the transplant surgery, including evaluating and preparing the actual donor, regardless of whether the transplant is attempted or completed, and recovery services after the donor procedure which are directly related to donating the organ or tissue.

6. Immunosuppressant maintenance drugs are covered when prescribed for a covered transplant.

1.13 High Dose Chemotherapy/Bone Marrow or Stem Cell Transplant
Benefits will be provided for high dose chemotherapy bone marrow or stem cell transplant treatment that is not Experimental/ Investigational, when performed pursuant to protocols approved by the institutional review board of any United States medical teaching college including, but not limited to, National Cancer Institute protocols that have been favorably reviewed and utilized by hematologists or oncologists experienced in dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants.

1.14 Clinical Trial Patient Cost Coverage

A. Definitions

Cooperative Group means a formal network of facilities that collaborate on research projects and have an established NIH-approved peer review program operating within the Group. Cooperative Group includes the National Cancer Institute Clinical Cooperative

Group, National Cancer Institute Community Clinical Oncology Program, AIDS Clinical Trials Group, and Community Programs for Clinical Research in AIDS.

Multiple Project Assurance Contract means a contract between an institution and the federal Department of Health and Human Services that defines the relationship of the institution to the federal Department of Health and Human Services, and sets out the responsibilities of the institution and the procedures that will be used by the institution to protect human subjects.

NIH means the National Institutes of Health.

Qualified Individual, as used in this section, means a Member who is eligible to participate in an approved clinical trial according to the trial protocol, with respect to the treatment of cancer or other life-threatening disease or condition, and the provider who recommended the Member for the clinical trial has concluded that the Member's participation in such trial is appropriate to treat the disease or condition, or the Member's participation is based on medical and scientific information.

Routine Patient Costs means the costs of all Medically Necessary items and health care services consistent with the Covered Services that are typically provided for a Qualified Individual who is not enrolled in a clinical trial that are incurred as a result of the treatment being provided to the Qualified Individual for purposes of the clinical trial. Routine Patient Costs do not include the investigational item, device, or service itself; items or services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

B. Covered Services

1. Benefits for Routine Patient Costs to a Qualified Individual in a clinical trial will be provided if the Qualified Individual's participation in the clinical trial is the result of:

   a) Treatment provided for a life-threatening disease or condition; or

   b) Prevention, early detection, and treatment studies on cancer.

2. Coverage for Routine Patient Costs will be provided only if:

   a) The treatment is being provided or the studies are being conducted in a Phase I, Phase II, Phase III, or Phase IV clinical trial for cancer; or,

   b) The treatment is being provided in a Phase I, Phase II, Phase III, or Phase IV clinical trial for any other life-threatening disease or condition;

   c) The treatment is being provided in a federally funded or approved clinical trial approved by one of the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Health Care Research and quality, the Centers for Medicare and Medicaid Services, an NIH Cooperative Group, an NIH Center, the FDA in the form of an investigational new drug application, the federal Department of Veterans Affairs, the federal Department of Energy or a qualified nongovernmental research entity to which the National Cancer Institute has awarded a support grant,, or an institutional review board of an institution in a state that has a Multiple Project Assurance Contract approved by the Office of Protection from Research Risks of the NIH;

d) The treatment is being provided under a drug trial that is exempt from the requirement of an investigational new drug application.

e) The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise;

f) There is no clearly superior, non-investigational treatment alternative;

g) The available clinical or pre-clinical data provides a reasonable expectation that the treatment will be at least as effective as the non-investigational alternative.

3. Coverage is provided for the Routine Patient Costs incurred for drugs and devices that have been approved for sale by the FDA whether or not the FDA has approved the drug or device for use in treating the Qualified Individual's particular condition, to the extent that the drugs or devices are not paid for by the manufacturer, distributor, or provider of that drug or device.

1.15 Diabetes Equipment and Supplies, and Self-Management Training

A. If deemed necessary, diabetes outpatient self-management training and educational services, including Medical Nutrition Therapy, will be provided through an in-person program supervised by an appropriately licensed, registered, or certified CareFirst-approved facility or health care provider whose scope of practice includes diabetes education or management.

B. Coverage information for diabetic equipment and supplies is located in Section 10, Medical Devices and Supplies and Section 11, Prescription Drugs.

1.16 Dental Services

Pediatric dental benefits for Members up to age 19 are described in Section 2. Benefits will be provided to all Members for the following:

Accidental Injury

A. Covered Benefits

Dental benefits will be provided to repair or replace Sound Natural Teeth that have been damaged or lost due to injury if the injury did not arise while or as a result of biting or chewing, and treatment is commenced within six (6) months of the injury or, if due to the nature of the injury, treatment could not begin within six (6) months of the injury, treatment began within six (6) months of the earliest date that it would be medically appropriate to begin such treatment.

As used in this provision, accidental injury means an injury to Sound Natural Teeth as a result of an external force or trauma resulting in damage to a tooth or teeth, surrounding bone and/or jaw.

B. Conditions and Limitations

Benefits are limited to Medically Necessary dental services as a restoration of the tooth or teeth or the initial placement of a bridge or denture to replace the tooth or teeth injured or lost as a direct and sole result of the accidental bodily injury. Except as listed here, or in Section 1.18, describing benefits for the treatment of cleft lip or cleft palate or both, dental care is excluded from coverage. Benefits for oral surgery are described in Section 1.17.

C. Exclusions

Injuries to teeth that are not Sound Natural Teeth are not covered. Injuries as a result of biting or chewing are not covered.

1.17 Oral Surgery

Benefits include:

A. Medically Necessary procedures, as determined by CareFirst, to attain functional capacity, correct a congenital anomaly (excluding odontogenic congenital anomalies or anomalies limited to the teeth), reduce a dislocation, repair a fracture, excise tumors, non-odontogenic cysts or exostoses, or drain abscesses involving cellulitis and are performed on the lips, tongue, roof, and floor of the mouth, sinuses, salivary glands or ducts, and jaws.

B. Medically Necessary procedures, as determined by CareFirst, needed as a result of an accidental injury, when the Member requests oral surgical services or dental services for Sound Natural Teeth and supporting structures or the need for oral surgical services or dental services for Sound Natural Teeth and supporting structures is identified in the patient's medical records within sixty (60) days of the accident. Benefits for such oral surgical services will be provided up to three (3) years from the date of injury.

C. Surgical treatment for temporomandibular joint syndrome (TMJ) if there is clearly demonstrable radiographic evidence of joint abnormality due to an illness.

All other procedures involving the teeth or areas surrounding the teeth including the shortening of the mandible or maxillae (orthognathic surgery) for Cosmetic or other purposes or for correction of the malocclusion unrelated to a functional impairment that cannot be corrected non-surgically are excluded.

1.18 Treatment for Cleft Lip or Cleft Palate or Both

Benefits will be provided for inpatient or outpatient expenses arising from orthodontics, oral surgery, otologic, audiological, and speech/language treatment for cleft lip or cleft palate or both.

1.19 Outpatient Surgical Procedures

A. Benefits are available for surgical procedures performed by a health care provider on an outpatient basis including, but not limited to, colonoscopy, sigmoidoscopy, and endoscopy.

B. Benefits are available for services in a hospital outpatient department or in an ambulatory surgical facility, in connection with a covered surgical procedure, including:

1. Use of operating room and recovery room.

2. Use of special procedure rooms.

3. Diagnostic procedures, laboratory tests, and radiology services.

4. Drugs, medications, solutions, biological preparations, and services associated with the administration of the same.

5. Medical and surgical supplies.

6. Blood, blood plasma and blood products, and related donor processing fees that are not replaced by or on behalf of the Member. Administration of infusions is covered.

1.20 Anesthesia Services for Medical or Surgical Procedures. Benefits are available for the administration of general anesthesia in connection with a covered medical or surgical procedure. To be eligible for separate coverage, a health care provider other than the operating surgeon or assistant at surgery must administer the anesthesia. For example, a local anesthetic used while performing a medical or surgical procedure is not generally viewed as a separately covered charge.

1.21 Reconstructive Surgery

Benefits for reconstructive surgery are limited to surgical procedures that are Medically Necessary, as determined by CareFirst, and operative procedures performed on structures of the body to improve or restore bodily function or to correct a deformity resulting from disease, trauma, or previous therapeutic intervention.

1.22 Reconstructive Breast Surgery
Benefits will be provided for reconstructive breast surgery resulting from a Mastectomy.

A. Reconstructive breast surgery means surgery performed as a result of a Mastectomy to reestablish symmetry between the two breasts. Reconstructive breast surgery includes:

1. Augmentation mammoplasty;

2. Reduction mammoplasty; and

3. Mastopexy.

B. Benefits are provided for all stages of reconstructive breast surgery performed on the non-diseased breast to establish symmetry with the diseased breast when reconstructive breast surgery on the diseased breast is performed.

C. Benefits are provided regardless of whether the Mastectomy was performed while the Member was covered under the [Evidence of Coverage; Agreement].

D. Coverage will be provided for treatment of physical complications at all stages of Mastectomy, including lymphedemas, in a manner determined in consultation with the Member and the Member's attending physician.

1.23 Limited Service Immediate Care
Coverage is provided for treatment of common conditions or ailments which require rapid and specific treatment that can be administered in a limited duration of time. Limited Service Immediate Care services are non-emergency and non-urgent services. Services are provided in Limited Service Immediate Care Centers, which are mini-medical office chains typically staffed by nurse practitioners with an on-call physician. Examples of common ailments for which a layperson who possesses an average knowledge of health and medicine would seek Limited Service Immediate Care, include but are not limited to: ear, bladder, and sinus infections, pink eye, flu, and strep throat.

1.24 Urgent Care Services
Benefits are available for Urgent Care received from an Urgent Care center.

1.25 Emergency Services
Benefits are available for Emergency Services received in or through a hospital emergency room. Benefits include coverage for the costs of a voluntary HIV test, performed during a Member's visit to a hospital emergency room, regardless of the reason for the hospital emergency room visit.

1.26 Ambulance Services
Benefits are available for Medically Necessary air and ground ambulance services as determined by CareFirst.

If the Member is outside the United States and requires treatment by a medical professional, benefits will be provided to transport the Member to the nearest location where more appropriate medical care is available. Benefits include air or ground ambulance services, when Medically Necessary.

SECTION 2
PEDIATRIC DENTAL SERVICES

2.1 Subject to the terms and conditions of this Description of Covered Services, benefits will be provided for the following Covered Dental Services when rendered and billed for by a Dentist as specified in the attached Schedules of Benefits.

2.2 Pediatric dental benefits for Members up to the end of the calendar year in which the Member turns age 19 will be provided in accordance with the High Option dental benefits of the Federal Employees Dental and Vision Insurance Program (FEDVIP) as specified in the Schedule of Benefits.

2.3 Class I - Preventive and Diagnostic Services

A. Services limited to twice per Benefit Period.

1. Oral examination including oral health risk assessment

2. Routine cleaning of teeth (dental prophylaxis)

3. Topical application of fluoride

4. Bitewing x-ray (not taken on the same date as those in B. below)

5. Pulp vitality tests; additional tests may be allowed for accidental injury and trauma, or other emergency

B. Services limited to one per 60 months

1. Intraoral complete series x-ray (full mouth x-ray including bitewings)

2. One panoramic x-ray and one additional set of bitewing x-rays

C. Services limited to once per tooth per 36 months: sealants on permanent molars

D. Space maintainers when Medically Necessary due to the premature loss of a posterior primary tooth

E. Services as required

1. Palliative Treatments once per date of service

2. Emergency Oral Exam once per date of service

3. Periapical and occlusal x-rays limited to the site of injury or infection

4. Professional consultation rendered by a Dentist, limited to one consultation per condition per Dentist other than the treating Dentist

5. Intraoral occlusal x-ray

6. One cephalometric x-ray

2.4 Class II - Basic Services

A. Direct placement fillings limited to:

1. Silver amalgam, resin-based composite, compomer, glass-ionomer or equivalent material accepted by the American Dental Association and/or the United States Food and Drug Administration

2. Direct pulp caps and indirect pulp caps

B. Non-Surgical periodontic services limited to:

1. Periodontal scaling and root planing once per 24 months per quadrant

2. Full mouth debridement to enable comprehensive periodontal procedure one per lifetime

3. Periodontal maintenance procedures four per 12 months

C. Simple extractions performed without general anesthesia once per tooth per lifetime

2.5 Class III - Major Services - Surgical

A. Surgical periodontic services

1. Gingivectomy or gingivoplasty limited to one treatment per 36 months per Member per quadrant or per tooth

2. Osseous Surgery (including flap entry and closure) limited to one treatment per 36 months per Member per quadrant

3. Limited or complete occlusal adjustments in connection with periodontal treatment when services are received on a different date than restorative services

4. Mucogingival Surgery limited to grafts and plastic procedures; one treatment per site limited to one site or quadrant every 36 months

B. Endodontics

1. Apicoectomy

2. Pulpotomy for deciduous teeth once per tooth per lifetime per Member

3. Root canal for permanent teeth once per tooth per lifetime per Member

4. Root canal retreatment performed on permanent teeth limited to once per tooth per lifetime per Member

5. Root resection once per tooth per lifetime per Member

6. Pulpal therapy once per tooth per lifetime per Member

7. Endodontic therapy once per tooth per lifetime per Member

C. Oral Surgical services as required

1. Simple and Surgical extractions, including impactions once per tooth per lifetime per Member

2. Oral Surgery, including treatment for cysts, tumors and abscesses

3. Biopsies of oral tissue if a biopsy report is submitted

4. General anesthesia, intravenous (IV) sedation/analgesia, analgesia, and non-intravenous conscious sedation when Medically Necessary and administered by a Dentist who has a license, permit, or certificate to administer conscious sedation or general anesthesia or board certified anesthesiologist (MD, DO, DDS, DMD).

6. Hemi-section

7. Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth

8. Vestibuloplasty

9. Services limited to once per lifetime per tooth:

   a) Coronectomy

   b) Tooth transplantation

   c) Surgical repositioning of teeth

   d) Alveoloplasty

   e) Frenulectomy

   f) Excision of pericoronal gingiva

2.6 Class IV - Major Services - Restorative

A. Crowns

1. Metal and/or porcelain/ceramic crowns and crown build-ups limited to one per 60 months per tooth

2. Metal and/or porcelain/ceramic inlays and onlays limited to one per 60 months per tooth

3. Stainless steel crowns

4. Recementation of crowns and/or inlays limited to once in any twelve (12) month period

5. Metal and/or porcelain/ceramic pontics limited to one per 60 months per tooth

B. Dental Implants are covered procedures only if determined to be Medically Necessary. If CareFirst determines an arch can be restored with a standard prosthesis or restoration, no benefits will be allowed for the individual implant or implant procedures, and only the second phase of treatment (the prosthodontic phase of placing of the implant crown or partial denture) will be a Covered Dental Service.

1. Endosteal implant limited to one per 60 months

2. Surgical placement of interim implant body limited to one per 60 months

3. Eposteal implant limited to one per 60 months

4. Transosteal implant limited to one per 60 months

5. Implant supported complete denture

6. Implant supported partial denture

C. Dentures

1. Partial removable dentures, upper or lower, limited to one per 60 months

2. Complete removable dentures, upper or lower, limited to one per 60 months

3. Pre-operative radiographs required

4. Pre-treatment estimate, as described in the Estimate of Eligible Benefits section is recommended for Members

5. Tissue conditioning prior to denture impression

6. Repairs to denture as required including: repair resin denture base, repair cast framework, addition of tooth or clasp to existing partial denture, replacement of broken tooth, repairs or replacement of clasp, recement fixed partial denture

D. Denture adjustments and relining limited to: Full or partial removable (upper or lower) dentures: once per 24 months, but not within six months of initial placement

E. Repair of prosthetic appliances and removable dentures, full and/or partial.

F. Occlusal guard, by report, limited to one per 12 months for Members age 13 and older

G. Occlusal adjustment, limited, if provided when no other restorative procedure is provided on the same date of service, limited to two per 12 months

H. Occlusal adjustment, complete, if provided when no other restorative procedure is provided on the same date of service, limited to one per 12 months

2.7 Class V - Orthodontic Services

A. Benefits for orthodontic services will only be available until the end of the calendar year in which the Member turns age 19 if the Member:

1. Has fully erupted permanent teeth with at least 1/2 to 3/4 of the clinical crown being exposed (unless the tooth is impacted or congenitally missing); and

2. Has a severe, dysfunctional, handicapping malocclusion and is determined to be Medically Necessary.

B. All comprehensive orthodontic services require a pre-treatment estimate (PTE) by CareFirst, as described in the Estimate of Eligible Benefits section. The following documentation must be submitted with the request for a PTE:

1. ADA 2006 or newer claim form with service code requested;

2. A complete series of intra-oral photographs;

3. Diagnostic study models (trimmed) with waxbites or OrthoCad electronic equivalent, and

4. Treatment plan including anticipated duration of active treatment.

C. Covered benefits if a PTE is approved

1. Retainers

    a) One set (included in comprehensive orthodontics)

    b) Replacement allowed one per arch per lifetime within 12 months of date of debanding, if necessary

    c) Rebonding or recementing fixed retainer

2. Pre-orthodontic treatment visit

3. Braces once per lifetime

4. Periodic treatment visits; not to exceed 24 months (the Member must be eligible for Covered Dental Services on each date of service).

D. Payment policy: one initial payment for comprehensive orthodontic treatment, a pre-orthodontic treatment visit and periodic orthodontic treatment visits (not to exceed 24 periodic orthodontic treatment visits).

1. When a Preferred Dentist or Participating Dentist provides the comprehensive orthodontic treatment, additional periodic orthodontic treatment visits beyond 24 will be the orthodontist's financial responsibility and not the Subscriber's. Subscribers may not be billed for broken, repaired, or replacement of brackets or wires. Visits to repair or replace brackets or wires are not separately reimbursable from periodic visits.

2. When a Non-Participating Dentist provides the comprehensive orthodontic treatment, additional periodic orthodontic treatment visits beyond 24 will not be Covered Dental Services. The Member is responsible for the difference between the CareFirst payment for Covered Dental Services and the Non-Participating Dentist's charge.

E. In cases where the Member has been approved for comprehensive orthodontic benefits, and the parent has decided they do not wish to have the child begin treatment at this time or any time in the near future, the provider may bill for their records, to include the treatment plan, radiographs, models, photos, etc. and explaining the situation on the claim for payment. The reimbursement for these records is the same as if the orthodontic services had been rendered.

F. If the case is denied, the provider will be informed that CareFirst will not cover the orthodontic treatment. However, Covered Dental Services will include the pre-orthodontic visit which included treatment plan, radiographs, and/or photos, records and diagnostic models for full treatment cases only.

SECTION 3
PEDIATRIC VISION SERVICES

3.1 Covered Services

Coverage will be provided for pediatric vision benefits for children up to age 19 in accordance with the Federal Employee Program Blue Vision high plan. Benefits include:

A. One routine eye examination, including dilation, if professionally indicated, each Benefit Period. A vision examination may include, but is not limited to:

1. Case history;

2. External examination of the eye and adnexa;

3. Ophthalmoscopic examination;

4. Determination of refractive status;

5. Binocular balance testing;

6. Tonometry test for glaucoma;

7. Gross visual field testing;

8. Color vision testing;

9. Summary finding; and

10. Recommendation, including prescription of corrective lenses.

B. Frames and Spectacle Lenses or Contact Lenses

1. Prescribed frames and spectacle lenses or contact lenses, including directly related provider services such as:

a) Measurement of face and interpupillary distance;

b) Quality assurance; and

c) Reasonable aftercare to fit, adjust and maintain comfort and effectiveness.

2. One pair of frames per Benefit Period; and

3. One pair of prescription spectacle lenses per Benefit Period

a) Spectacle lenses include choice of glass or plastic lenses, all lens powers (single vision, bifocal, trifocal, lenticular), fashion and gradient tinting, oversized glass-grey #3 prescription sunglass lenses, ultraviolet protective coating, standard progressives, and plastic photosensitive lenses (Transitions®).

b) Polycarbonate lenses are covered in full for monocular patients and patients with prescriptions > +/- 6.00 diopters.

c) All spectacle lenses include scratch resistant coating with no additional Copayment. There may be an additional charge at Walmart and Sam's Club

4. Contact Lenses

a) Contact lens evaluation, fitting, and follow-up care.

b) Elective contact lenses (in place of frames and spectacle lenses):

(1) One pair of elective prescription contact lenses per Benefit Period; or,

(2) Multiple pairs of disposable prescription contact lenses per Benefit Period.

c) One pair of Medically Necessary prescription contact lenses per Benefit Period in lieu of other eyewear.

(1) Prior authorization must be obtained from the Vision Care Designee by calling the Vision Care Designee at the telephone number on the Member's identification card.

(2) Contact lenses may be determined to be Medically Necessary and appropriate in the treatment of patients affected by certain conditions. Contact lenses may be Medically Necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression. Contact lenses may be determined to be Medically Necessary in the treatment of the following conditions: keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders, and/or irregular astigmatism.

C. Low vision services, including one comprehensive Low Vision evaluation every 5 years, 4 follow-up visits in any 5-year period and prescribed low vision aid optical devices, such as high-powered spectacles, magnifiers and telescopes.

1. Ophthalmologists and optometrists specializing in low vision care will evaluate and prescribe optical devices, and provide training and instruction to maximize the remaining usable vision for Members with low vision.

2. Prior authorization is required for low vision services. Contracting Vision Providers will obtain the necessary prior authorization for these services.

D. Covered Vision Services and benefits for services provided by Non-Contracting Vision Providers are limited. See the Schedule of Benefits.

3.2 Warranty

The Vision Care Designee's collection frames and all eyeglass lenses manufactured in the Vision Care Designee laboratories are guaranteed for one year from the original date of dispensing. Warranty limitations may apply to provider-supplied or retailer-supplied frames and/or eyeglass lenses. The Contracting Vision Provider can provide the details of the warranty that is available to the Member.

3.3 Limitations

Benefit limited to Members up to age 19. If Member is under age 19 at the start of the Benefit Period but turns 19 during the Benefit Period, then the Member will receive Covered Vision Services through the rest of that Calendar Year. Benefits for the treatment of medical conditions of the eye are covered under Section 1.

[SECTION 4
ADULT VISION SERVICES

4.1 Covered Services. Coverage will be provided for Members age 19 and over for one (1) routine eye examination, including dilation, if professionally indicated, each Benefit Period. A vision examination may include, but is not limited to:

A. Case history;

B. External examination of the eye and adnexa;

C. Ophthalmoscopic examination;

D. Determination of refractive status;

E. Binocular balance testing;

F. Tonometry test for glaucoma;

G. Gross visual field testing;

H. Color vision testing;

I. Summary finding; and

J. Recommendation, including prescription of corrective lenses.

4.2 Limitations
Benefits will not be provided for frames, lenses and contact lenses. Benefits for treatment of medical conditions of the eye are covered under Section 1.**]**

SECTION 5
INPATIENT HOSPITAL SERVICES

HOSPITAL ADMISSIONS MUST BE AUTHORIZED OR APPROVED BY CAREFIRST UNLESS EXCEPTIONS ARE STATED.

5.1 Covered Inpatient Hospital Services

A Member will receive benefits for the Covered Services listed below when admitted to a hospital. Coverage of inpatient hospital services is subject to certification by utilization management for Medical Necessity. Benefits are provided for:

A. Room and Board
Room and board in a semiprivate room (or in a private room when Medically Necessary as determined by CareFirst).

B. Physician, Medical, and Surgical Services
Medically Necessary inpatient physician, medical, and surgical services provided by or under the direction of the attending physician and ordinarily furnished to a patient while hospitalized.

C. Services and Supplies
Related inpatient services and supplies that are not Experimental/Investigational, as determined by CareFirst, and ordinarily furnished by the hospital to its patients, including:

1. The use of:

   a) Operating rooms;

   b) Treatment rooms; and

   c) Special equipment in the hospital.

2. Drugs, medications, solutions, biological preparations, anesthesia, and services associated with the administration of the same.

3. Medical and surgical supplies.

4. Blood, blood plasma, and blood products, and related donor processing fees that are not replaced by or on behalf of the Member. Administrations of infusions and transfusions are covered.

5. Surgically implanted Prosthetic Devices that replace an internal part of the body. This includes hip joints, skull plates, cochlear implants, and pacemakers. Available benefits under this provision do not include items such as dental implants, fixed or removable dental Prosthetics, artificial limbs, or other external Prosthetics, which may be provided under other provisions of this Description of Covered Services.

6. Medical social services.

5.2 Number of Hospital Days Covered

Provided the conditions, including the requirements below, are met and continue to be met, as determined by CareFirst, hospital benefits for inpatient hospital services will be provided as follows:

A. Hospitalization for Rehabilitation
Benefits are provided for an admission or transfer to a CareFirst approved facility for

rehabilitation. Benefits provided during any admission will not exceed any applicable benefit limitation. The limit, if any, on hospitalization for rehabilitation applies to any portion of an admission that:

1. Is required primarily for Physical Therapy or other rehabilitative care; and

2. Would not be Medically Necessary based solely on the Member's need for inpatient acute care services other than for rehabilitation.

B. Inpatient Coverage Following a Mastectomy
Coverage will be provided for a minimum hospital stay of not less than:

1. Forty-eight (48) hours following a radical or modified radical Mastectomy; and

2. Twenty-four (24) hours following a partial Mastectomy with lymph node dissection.

In consultation with the Member's attending physician, the Member may elect to stay less than the minimum prescribed above when appropriate.

C. Hysterectomies
Coverage will be provided for vaginal hysterectomies and abdominal hysterectomies. Coverage includes a minimum stay in the hospital of:

1. Not less than twenty-three (23) hours for a laparoscopy-assisted vaginal hysterectomy; and

2. Not less than forty-eight (48) hours for a vaginal hysterectomy.

In consultation with the Member's attending physician, the Member may elect to stay less than the minimum prescribed above when appropriate.

D. Childbirth
Coverage will be provided for a minimum hospital stay of not less than:

1. Forty-eight (48) hours for both the mother and newborn following a routine vaginal delivery;

2. Ninety-six (96) hours for both the mother and newborn following a routine cesarean section.

Prior authorization is not required for maternity admissions.

Whenever a mother is required to remain hospitalized after childbirth for medical reasons and the mother requests that the newborn remain in the hospital, coverage includes additional hospitalization for the newborn for up to four (4) days.

If the delivery occurs in the hospital, the length of stay begins at the time of the delivery. If the delivery occurs outside of the hospital, the length of stay begins upon admission to the hospital. The Member and the attending physician may agree to an early discharge.

Non-routine care of the newborn, either during or following the mother's covered hospitalization, requires that the newborn be covered as a Member in the newborn's own right. Section [2.7] of the [Out-of-Network] [Evidence of Coverage; Agreement] describes the steps, if any, necessary to enroll a newborn Dependent child.

5.3 Other Inpatient Services

Benefits are available for all other care in the nature of usual hospital services that are Medically Necessary for the care and treatment of the patient, provided that those services cannot be rendered in an outpatient setting and are not otherwise specifically excluded.

SECTION 6
SKILLED NURSING FACILITY SERVICES

See Section 15, Utilization Management, for Covered Services that require prior authorization.

6.1 Covered Skilled Nursing Facility Services

When the Member meets the conditions for coverage listed in Section 6.2, the services listed below are available to Members in a Skilled Nursing Facility:

A. Room and board in a semiprivate room;

B. Inpatient physician and medical services provided by or under the direction of the attending physician; and

C. Services and supplies that are not Experimental/Investigational, as determined by CareFirst, and ordinarily furnished by the facility to inpatients for diagnosis or treatment.

6.2 Conditions for Coverage

Skilled Nursing Facility care must be authorized or approved by CareFirst as meeting the following conditions for coverage:

A. The admission to the Skilled Nursing Facility must be a substitute for hospital care (i.e., if the Member were not admitted to a Skilled Nursing Facility, he or she would have to be admitted to a hospital).

B. Skilled Nursing Facility benefits will not be provided in a facility that is used primarily as a rest home or a home for the aged, or in a facility for the care of drug addiction or alcoholism.

C. The Member must require Skilled Nursing Care or skilled rehabilitation services which are:

1. Required on a daily basis;

2. Not Custodial; and

3. Only provided on an inpatient basis.

6.3 Custodial Care is Not Provided

Benefits will not be provided for any day in a Skilled Nursing Facility that CareFirst determines is primarily for Custodial Care. Services may be deemed Custodial Care even if:

A. A Member cannot self-administer the care;

B. No one in the Member's household can perform the services;

C. Ordered by a physician;

D. Necessary to maintain the Member's present condition; or

E. Covered by Medicare.

SECTION 7
HOME HEALTH CARE SERVICES

See Section 15, Utilization Management, for Covered Services that require prior authorization.

7.1 Covered Home Health Care Services
Benefits are provided for:

A. Continued care and treatment provided by or under the supervision of a Registered Nurse (RN) or Licensed Practical Nurse (LPN). Services of a home health aide, medical social worker, or registered dietician may be provided, but must be performed under the supervision of a licensed professional (RN or LPN) nurse.

B. Drugs and medications
Drugs and medications directly administered to the patient during a covered home health care visit and incidental Medical Supplies directly expended in the course of a covered home health care visit are covered.

C. Home Health Care Services authorized or approved by CareFirst as Medically Necessary under the utilization management requirements as meeting the conditions for coverage.

Purchase or rental of Durable Medical Equipment is not covered under this provision. See Section 10.3.A, Durable Medical Equipment, for benefit information.

7.2 Conditions for Coverage
Benefits are provided when:

A. The Member must be confined to home due to a medical, non-psychiatric condition. "Home" cannot be an institution, convalescent home, or any facility which is primarily engaged in rendering medical or rehabilitative services to sick, disabled, or injured persons.

B. The Home Health Care visits are a substitute for hospital care or for care in a Skilled Nursing Facility (i.e., if Home Health Care visits were not provided, the Member would have to be admitted to a hospital or Skilled Nursing Facility).

C. The Member requires and continues to require Skilled Nursing Care or rehabilitation services in order to qualify for home health aide services or other types of Home Health Care Services.

D. The need for Home Health Care Services is not Custodial in nature.

E. Services of a home health aide, medical social worker, or registered dietician must be performed under the supervision of a licensed professional nurse (RN or LPN).

F. All services must be arranged and billed by the Qualified Home Health Agency. Providers may not be retained directly by the Member.

7.3 Additional Home Health Care Benefits

A. Home Visits Following Surgical Removal of a Testicle
For a Member who receives less than 48 hours of inpatient hospitalization following the surgical removal of a testicle, or who undergoes the surgical removal of a testicle on an outpatient basis, benefits will be provided for:

1. One home visit scheduled to occur within twenty-four (24) hours after discharge from the hospital or outpatient health care facility; and

2. An additional home visit if prescribed by the Member's attending physician.

3. Benefits provided under this provision do not count toward any Home Health Care visit maximum.

B. Home Visits Following a Mastectomy

1. For a Member who has a shorter hospital stay than that provided under Section 5.2.B, Inpatient Coverage Following a Mastectomy, or who undergoes a Mastectomy on an outpatient basis, benefits will be provided for:

   a) One home visit scheduled to occur within twenty-four (24) hours after discharge from the hospital or outpatient health care facility; and

   b) An additional home visit if prescribed by the Member's attending physician.

2. For a Member who remains in the hospital for at least the length of time provided in Section 5.2.B, Inpatient Coverage Following a Mastectomy, coverage will be provided for a home visit if prescribed by the Member's attending physician

3. Benefits provided under this provision do not count toward any Home Health Care visit maximum.

C. Postpartum Home Visits

Home visits following delivery are covered in accordance with the most current standards published by the American College of Obstetricians and Gynecologists.

1. For a mother and newborn child who have a shorter hospital stay than that provided under Section 5.2.D, Childbirth, benefits will be provided for:

   a) One home visit scheduled to occur within 24 hours after hospital discharge; and

   b) An additional home visit if prescribed by the attending physician.

2. For a mother and newborn child who remain in the hospital for at least the length of time provided under Section 5.2.D, Childbirth, benefits will be provided for a home visit if prescribed by the attending physician.

3. Benefits provided under this provision do not count toward any Home Health Care visit maximum.

SECTION 8
HOSPICE CARE SERVICES

See Section 15, Utilization Management, for Covered Services that require prior authorization.

8.1 Covered Hospice Care Services

Benefits will be provided for the services listed below when provided by a Qualified Hospice Care Program. Coverage for hospice care services is subject to certification of the need and continued appropriateness of such services in accordance with CareFirst utilization management requirements.

A. Inpatient and outpatient care;

B. Intermittent Skilled Nursing Care;

C. Medical social services for the terminally ill patient and his or her Immediate Family;

D. Counseling, including dietary counseling, for the terminally ill Member;

E. Non-Custodial home health visits.

F. Services, visits, medical/surgical equipment, or supplies, including equipment and medication required to maintain the comfort and manage the pain of the terminally ill Member;

G. Laboratory test and x-ray services;

H. Medically Necessary ground ambulance, as determined by CareFirst;

I. Family Counseling will be provided to the Immediate Family and the Family Caregiver before the death of the terminally ill Member, when authorized or approved by CareFirst; and

J. Bereavement Counseling will be provided for the Immediate Family or Family Caregiver of the Member for the six (6) month period following the Member's death or fifteen (15) visits, whichever occurs first.

8.2 Conditions for Coverage

Hospice care services must be certified by CareFirst, provided by a Qualified Hospice Care Program, and meet the following conditions for coverage:

A. The Member must have a life expectancy of six (6) months or less;

B. The Member's attending physician must submit a written hospice care services plan of treatment to CareFirst;

C. The Member must meet the criteria of the Qualified Hospice Care Program;

D. The need and continued appropriateness of hospice care services must be certified by CareFirst as meeting the criteria for coverage in accordance with CareFirst utilization management requirements.

8.3 Hospice Eligibility Period

The hospice eligibility period begins on the first date hospice care services are rendered and terminates one hundred eighty (180) days later or upon the death of the terminally ill Member, if sooner. If the Member requires an extension of the eligibility period, the Member or the Member's representative must notify CareFirst in advance to request an extension of benefits. CareFirst reserves the right to extend the eligibility period on an individual case basis if CareFirst

determines that the Member's prognosis and continued need for services are consistent with a program of hospice care services.

SECTION 9
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

HOSPITAL ADMISSIONS MUST BE AUTHORIZED OR APPROVED BY THE MENTAL HEALTH AND SUBSTANCE ABUSE MANAGEMENT PROGRAM

9.1 Definitions

Mental Illness and Emotional Disorders are broadly defined as including any mental disorder, mental illness, psychiatric illness, mental condition, or psychiatric condition (whether organic or non-organic, whether of biological, non-biological, chemical or non-chemical origin, and irrespective of cause, basis, or inducement). This includes, but is not limited to, psychoses, neurotic disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems. (This is intended to include disorders, conditions and illnesses classified on Axes I and II in the current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, Washington, D.C.)

Mental Health and Substance Abuse Management Program refers to utilization management, benefits administration, and provider network activities administered by or on behalf of CareFirst to ensure that mental health and Substance Abuse services are Medically Necessary and provided in a cost-effective manner.

Partial Hospitalization means the provision of medically directed intensive or intermediate short-term treatment in a licensed or certified facility or program for treatment of Mental Illnesses, Emotional Disorders, and Drug and Alcohol Abuse.

Qualified Partial Hospitalization Program means a licensed or certified facility or program that provides medically directed intensive or intermediate short-term treatment for Mental Illness, Emotional Disorder, Drug Abuse or Alcohol Abuse for a period of less than twenty-four (24) hours, but more than four (4) hours in a day.

Qualified Treatment Facility means a non-hospital residential facility certified by the District of Columbia or by any jurisdiction in which it is located, as a qualified non-hospital provider of treatment for Drug Abuse, Alcohol Abuse, Mental Illness, or any combination of these, in a residential setting. A non-hospital residential facility includes any facility operated by the District of Columbia, any state or territory or the federal government to provide these services in a residential setting. It is not a facility licensed as a general or special hospital. A non-hospital residential facility also must meet or exceed guidelines established for such a facility by CareFirst.

Substance Abuse means:

A. Alcohol Abuse means any pattern of pathological use of alcohol that causes impairment in social or occupational functioning, or that produces physiological dependency evidenced by physical tolerance or by physical symptoms when it is withdrawn.

B. Drug Abuse means any pattern of pathological use of drugs that causes impairment in social or occupational functioning, or that produces physiological dependency evidenced by physical tolerance or by physical symptoms when it is withdrawn.

9.2 Outpatient Mental Health and Substance Abuse Services
Covered Services include the following:

A. Diagnosis and treatment for Mental Illness and Emotional Disorders at health care provider offices, other outpatient health care provider medical offices and facilities, and in Qualified Partial Hospitalization Programs.

B. Diagnosis and treatment for Substance Abuse, including detoxification and rehabilitation services as an outpatient in a covered alcohol or drug rehabilitation program or Qualified Partial Hospitalization Program designated by CareFirst.

C. Other covered medical services and medical Ancillary Services for conditions related to Mental Illness, Emotional Disorders, and Substance Abuse.

D. Office visits for medication management in connection with Mental Illness, Emotional Disorders, and Substance Abuse.

E. Methadone maintenance treatment.

F. Partial Hospitalization in a Qualified Partial Hospitalization Program.

9.3 Inpatient Mental Health and Substance Abuse Services

Benefits are provided when the Member is admitted as an inpatient in a hospital or other CareFirst-approved health care facility for treatment of Mental Illness, Emotional Disorders, and Substance Abuse as follows:

A. Hospital benefits will be provided, as described in Section 5, Inpatient Hospital Services, of this Description of Covered Services, on the same basis as a medical (non-Mental Health or Substance Abuse) admission.

B. Services provided to a hospitalized Member, including physician visits, charges for intensive care, or consultative services, only if CareFirst determines that the health care provider rendered services to the Member and that such services were medically required to diagnose or treat the Member's condition.

The following benefits apply if the Member is an inpatient in a hospital covered under inpatient hospitalization benefits following CareFirst certification of the need and continued appropriateness of such services in accordance with CareFirst utilization management requirements:

1. Health care provider visits during the Member's hospital stay;

2. Intensive care that requires a health care provider's attendance;

3. Consultation by another health care provider when additional skilled care is required because of the complexity of the Member's condition; and

C. Benefits are available for diagnosis and treatment for Substance Abuse, including inpatient detoxification and rehabilitation services in an acute care hospital or Qualified Treatment Facility. Members must meet the applicable criteria for acceptance into, and continued participation in, treatment facilities/programs, as determined by CareFirst.

SECTION 10
MEDICAL DEVICES AND SUPPLIES

10.1 Definitions

Durable Medical Equipment means equipment which:

A. Is primarily and customarily used to serve a medical purpose;

B. Is not useful to a person in the absence of illness or injury;

C. Is ordered or prescribed by a health care provider;

D. Is consistent with the diagnosis;

E. Is appropriate for use in the home;

F. Is reusable; and

G. Can withstand repeated use.

Inherited Metabolic Disease means a disease caused by an inherited abnormality of body chemistry, including a disease for which the state screens newborn babies.

Low Protein Modified Food Product means a food product that is:

A. Specially formulated to have less than 1 gram of protein per serving; and

B. Intended to be used under the direction of a physician for the dietary treatment of an Inherited Metabolic Disease.

Low Protein Modified Food Product does not include a natural food that is naturally low in protein.

Medical Devices means Durable Medical Equipment, medical formulas, Medical Supplies, Orthotic Devices and Prosthetic Devices.

Medical Food means a food that is:

A. Intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation; and

B. Formulated to be consumed or administered under the direction of a physician.

Medical Supplies means items that:

A. Are primarily and customarily used to serve a medical purpose;

B. Are not useful to a person in the absence of illness or injury;

C. Are ordered or prescribed by a health care provider;

D. Are consistent with the diagnosis;

E. Are appropriate for use in the home;

F. Cannot withstand repeated use; and

G. Are usually disposable in nature.

Orthotic Devices means orthoses and braces which:

A. Are primarily and customarily used to serve a therapeutic medical purpose;

B. Are prescribed by a health care provider;

C. Are corrective appliances that are applied externally to the body to limit or encourage its activity, to aid in correcting or preventing deformity, or to provide mechanical support;

D. May be purely passive support or may make use of spring devices; and

E. Include devices necessary for post-operative healing.

Prosthetic Devices means devices which:

A. Are primarily intended to replace all or part of an organ or body part that has been lost due to disease or injury; or

B. Are primarily intended to replace all or part of an organ or body part that was absent from birth; or

C. Are intended to anatomically replace all or part of a bodily function which is permanently inoperative or malfunctioning; and

D. Are prescribed by a health care provider; and

E. Are removable and attached externally to the body.

10.2 Covered Services

A. Durable Medical Equipment
Rental, or, (at CareFirst's option), purchase and replacements or repairs of Medically Necessary Durable Medical Equipment prescribed by a health care provider for therapeutic use for a Member's medical condition.

[CareFirst's payment for rental will not exceed the total cost of purchase.] CareFirst's payment is limited to the least expensive Medically Necessary Durable Medical Equipment adequate to meet the Member's medical needs. [CareFirst's payment for Durable Medical Equipment includes related charges for handling, delivery, mailing, shipping, and taxes.]

B. Medical Supplies

C. Medical Foods and Low Protein Modified Food Products
Medical Foods and Low Protein Modified Food Products for the treatment of Inherited Metabolic Diseases are covered if the Medical Foods or Low Protein Modified Food Products are:

1. Prescribed as Medically Necessary for the therapeutic treatment of Inherited Metabolic Diseases; and;

2. Administered under the direction of a physician.

D. Nutritional Substances
Enteral and elemental nutrition when Medically Necessary as determined by CareFirst.

E. Diabetes Equipment and Supplies

1. Coverage will be provided for all Medically Necessary and medically appropriate equipment and diabetic supplies necessary for the treatment of diabetes (Types I and II), or elevated blood glucose levels induced by pregnancy.

2. Coverage includes Medically Necessary and medically appropriate equipment and diabetic supplies necessary for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes.

3. Benefits for insulin syringes and other diabetic supplies described herein are covered in Section 11, Prescription Drugs. All other diabetic equipment is covered as a medical device or supply.

F. Hair Prosthesis
Benefits are available for a hair prosthesis when prescribed by a treating oncologist and the hair loss is a result of chemotherapy or radiation treatment for cancer.

G. Orthotic Devices and Prosthetic Devices
Benefits include:

1. Supplies and accessories necessary for effective functioning of a Covered Service;

2. Repairs or adjustments to Medically Necessary devices that are required due to bone growth or change in medical condition, reasonable weight loss or reasonable weight gain, and normal wear and tear during normal usage of the device; and

3. Replacement of Medically Necessary devices when repairs or adjustments fail and/or are not possible.

10.3 Repairs
Benefits for the repair, maintenance, or replacement of covered Durable Medical Equipment are limited as follows:

A. Coverage of maintenance costs is limited to routine servicing such as testing, cleaning, regulating, and checking of equipment.

B. Coverage of repairs costs is limited to adjustment required by normal wear or by a change in the Member's condition, and repairs necessary to make the equipment/appliance serviceable. Repair will not be authorized if the repair costs exceed the market value of the appliance, prosthetic, or equipment.

C. Replacement coverage is limited to once every two (2) years due to irreparable damage and/or normal wear, or a significant change in medical condition. Replacement costs necessitated as a result of malicious damage, culpable neglect, or wrongful disposition of the equipment or device on the part of the Member or of a family member are not covered.

10.4 Benefit Limits

Benefits are limited to the least expensive Medically Necessary Durable Medical Equipment, Medical Supply, Orthotic Device or Prosthetic adequate to meet the patient's medical needs.

Purchase or rental of any Medical Device is at the discretion of CareFirst. Benefits will be limited to the lower cost of purchase or rental, taking into account the length of time the Member

requires, or is reasonably expected to require the equipment, and the durability of the equipment, etc. The purchase price or rental cost must be the least expensive of its type adequate to meet the medical needs of the Member. If the Member selects a deluxe version of the appliance, device, or equipment not determined by CareFirst to be Medically Necessary, CareFirst will pay an amount that does not exceed CareFirst's payment for the basic device (minus any Member Copayment or Coinsurance) and the Member will be fully responsible for paying the remaining balance.

10.5 Responsibility of CareFirst

CareFirst will not be liable for any claim, injury, demand, or judgment based on tort or other grounds (including warranty of equipment), arising out of or in connection with the rental, sale, use, maintenance, or repair of Prosthetic Devices, corrective appliances or Durable Medical Equipment, whether or not covered under this Description of Covered Services.

SECTION 11
PRESCRIPTION DRUGS

11.1 [Covered Services
Benefits will be provided for Prescription Drugs, including but not limited to:

A. Any self-administered contraceptive drug or device, including a contraceptive drug and device on the Preferred Preventive Drug List, that is approved by the FDA for use as a contraceptive and is obtained under a prescription written by an authorized prescriber. See Section 1.5.C, Contraceptive Methods and Counseling, for additional coverage of contraceptive drugs and devices.

B. Human growth hormones. Prior authorization is required.

C. Any drug that is approved by the FDA as an aid for the cessation of the use of tobacco products and is obtained under a prescription written by an authorized prescriber, including drugs listed in the Preferred Preventive Drug List.

Nicotine Replacement Therapy. Nicotine Replacement Therapy means a product, including a product on the Preferred Preventive Drug List that is used to deliver nicotine to an individual attempting to cease the use of tobacco products, approved by the FDA as an aid for the cessation of the use of tobacco products and obtained under a prescription written by an authorized prescriber. Coverage for Nicotine Replacement Therapy will be provided on an unlimited yearly basis.

D. Injectable medications that are self-administered and the prescribed syringes.

E. Standard covered items such as insulin, glucagon and anaphylaxis kits.

F. Fluoride products.

G. Diabetic Supplies.

H. Oral chemotherapy drugs.

I. Hormone replacement therapy drugs.

11.2 Mail Order Program. All Members have the option of ordering Prescription Drugs via mail order. Members ordering Prescription Drugs through the mail order program will be entitled to a thirty-four (34) day supply for non-Maintenance Drugs and a ninety (90) day supply for Maintenance Drugs.**]**

SECTION 12
PATIENT-CENTERED MEDICAL HOME

12.1 [Definitions

Care Coordination Team means the health care providers involved in the collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet the Member's health needs through communication and available resources to promote quality cost-effective outcomes.

Care Plan means the plan directed by a health care provider, and coordinated by a nurse coordinator and Care Coordination Team, with engagement by the Qualifying Individual. The Care Plan is created in accordance with the PCMH goals and objectives.

Patient-Centered Medical Home Program ("PCMH") means medical and associated services directed by the PCMH team of medical professionals to:

A. Foster the health care provider's partnership with a Qualifying Individual and, where appropriate, the Qualifying Individual's primary caregiver;

B. Coordinate ongoing, comprehensive health care services for a Qualifying Individual; and

C. Exchange medical information with CareFirst, other providers and Qualifying Individuals to create better access to health care, increase satisfaction with medical care, and improve the health of the Qualifying Individual.

Qualifying Individual means a Member with a chronic condition, serious illness or complex health care needs, as determined by CareFirst, requiring coordination of health services and who agrees to participate in the PCMH.

12.2 Covered Benefits
Benefits will be provided for the costs associated with the coordination of care for the Qualifying Individual's medical conditions, including:

A. Assess the Qualifying Individual's medical needs;

B. Provide liaison services between the Qualifying Individual and the health care provider(s) and the Care Coordination Team;

C. Create and supervise the Care Plan;

D. Educate the Qualifying Individual and family regarding the Qualifying Individual's disease and self-care techniques;

E. Arrange consultations with Specialists and assist with obtaining Medically Necessary supplies and services, including community resources, for the Member; and

F. Assess treatment compliance.

12.3 Limitations
Benefits provided through the Patient-Centered Medical Home Program are available only when provided by a CareFirst-approved health care provider who has elected to participate in the PCMH.]

SECTION 13
COMPLEX CHRONIC OR HIGH RISK ACUTE DISEASE MANAGEMENT

13.1 [Definitions.

Care Plan means the plan of treatment created for a Qualified Individual under the Patient-Centered Medical Home Program (PCMH), through CareFirst Complex Case Management working in conjunction with the Qualified Individual's treating physician or nurse practitioner, or through a Chronic Care Coordination Program developed or implemented by a Chronic Care Coordinator.

Chronic Care Coordinator (CCC) means a registered nurse who develops and implements treatment plans for Qualified Individuals with chronic medical conditions in coordination with those treating physicians or nurse practitioners who do not participate in the CareFirst PCMH.

Complex Case Management (CCM) means the coordination of specialty services provided to a Qualified Individual with advanced or critical illnesses by Specialty Case Managers (SCM).

Designated Provider means a provider of a Chronic Care Coordination Program (CCP), Comprehensive Medication Review (CMR), Enhanced Monitoring Program (EMP), Expert Consultation Program (ECP), or Home-Based Services Program (HBS), outlined in this section, who has been contracted by CareFirst to provide these services and who has agreed to participate in care coordination activities in cooperation with CareFirst for Qualified Individuals with complex chronic disease or high risk acute conditions.

Home-Based Care Management Plan means the designated medical and associated services prescribed for a Qualified Individual with a high risk of admission or readmission to a hospital.

Home Care Coordinator (HCC) means a registered nurse or other provider licensed or otherwise authorized by law to provide home care working in conjunction with the Qualified Individual's treating physician, nurse practitioner, SCM or LCC.

Local Care Coordinator (LCC) means a registered nurse who develops and implements Care Plans for Qualified Individuals with chronic medical conditions in coordination with those treating physicians or nurse practitioners who participate in the CareFirst PCMH program.

Qualified Individual, as used in this section, means a Member who:

A. Is accepted by CareFirst into one or more of the programs described in this section. CareFirst will consult with the treating physician or nurse practitioner in order to determine whether the Member has a medical condition which meets the parameters for participation in one or more of the programs. CareFirst retains final authority to determine whether someone who meets the parameters for participation in a program will be accepted as a Qualified Individual.

B. Consents to participate and complies with all elements of the program(s) in which he/she qualifies.

C. Continues to meet the program criteria for participation and participates fully with any applicable plan of treatment. CareFirst and the Qualified Individual's treating physician or nurse practitioner will determine whether the Member is cooperating with the Home-Based Care Management Plan, Care Plan and/or plan of treatment.

Specialty Case Manager (SCM) means a registered nurse who works with a treating physician or nurse practitioner in order to coordinate the care needs of Qualified Individuals with complex medical conditions in accordance with the guiding principles of case management for complex

specialty care including, but not limited to, oncology, hospice, rehabilitation, trauma, and high risk pregnancy.

13.2 The following benefits are available to Qualified Individuals to manage the care of complex chronic or high-risk acute diseases when provided by Designated Providers or through CareFirst :

A. Chronic Care Coordination Program (CCP). Benefits will be provided for a Designated Provider to work telephonically or otherwise with a chronically ill Qualified Individual and his/her treating physician or nurse practitioner to develop and implement a treatment plan.

B. Complex Case Management (CCM). Specialty Case Managers will initiate and perform CCM services, as deemed Medically Necessary by the Member's treating physician or nurse practitioner and CareFirst . Benefits include:

1. Assessment of Qualified Individual/family needs related to understanding health care status and physician treatment plans, self-care, compliance capability, and continuum of care;

2. Education of Qualified Individual/family regarding illness, physician treatment plans, self-care techniques, treatment compliance, and continuum of care;

3. Assistance in navigating and coordinating health care services and understanding benefits;

4. Assistance in arranging for a primary care physician to deliver and coordinate the Qualified Individual's care with Specialty Case Managers;

5. Assistance in arranging consultation(s) with physician Specialists;

6. Locating community resources, and other organizations/support services to supplement the Care Plan;

7. Implementation of a Care Plan in consultation with the Qualified Individual's treating physician or nurse practitioner.

C.. Comprehensive Medication Review (CMR). Benefits will be provided for a pharmacist's review of medications and consultation with the Qualified Individual to improve the effectiveness of pharmaceutical therapy.

D. Enhanced Monitoring Program (EMP). Benefits will be provided for the medical equipment and monitoring services provided to a Qualified Individual with a chronic condition or disease in conjunction with the EMP for maintenance of the Qualified Individual's chronic condition or disease.

E. Expert Consultation Program (ECP). Benefits will be provided for a review by a Specialist of a Qualified Individual's medical records where the Qualified Individual has a complex or rare condition or multiple conditions or diseases for which the course of treatment requires unique expertise.

F. Home-Based Services Program (HBS). Benefits will be provided for medical and associated services specifically outlined in the Home-Based Care Management Plan.

1. The HBS coordinates care through an SCM or LCC for Qualified Individuals in a Care Plan who need considerable support at home, sometimes on a prolonged basis. Services provided may include a home health aide, psycho-social services and other behavioral health services as well as medication management and

support in activities of daily living. If such services are needed, they are provided following a home-based assessment by an HCC and become part of the overall plan of care maintained by the LCC or SCM responsible for the Qualified Individual.

2. The need for a Home-Based Care Management Plan is determined by the CareFirst SCM or LCC, working under the direction of the Qualified Individual's treating physician or nurse practitioner. Benefits will be provided for the HBS when the Qualified Individual is specifically referred to the HBS by an SCM or an LCC for full assessment and integrated home-based services pursuant to a Home-Based Care Management Plan. To be eligible for the HBS, the Qualified Individual must have a home-based assessment performed and completed by a Designated Provider.

   A person is deemed to be in a Home-Based Care Management Plan only after the home-based assessment is completed and the plan is subsequently approved by the Qualified Individual's treating physician or nurse practitioner and the CareFirst SCM or LCC.

3. To maintain participation in the HBS, the Qualified Individual must:

   a) Participate fully with the Care Plan and Home-Based Care Management Plan as determined by CareFirst and the Qualified Individual's treating physician or nurse practitioner; and,

   b) Engage in regular communication with the HCC, LCC and/or SCM.

4. Covered Services rendered to the Qualified Individual provided through or as a result of the Home-Based Care Management Plan will not count toward any visit limits stated in the Schedule of Benefits.

13.3 Member Cost-Sharing.

A. Any applicable Deductibles, Copayments and/or Coinsurance will be waived for services provided by a CCC, an HCC, an LCC, or a Care Coordination Team that are Designated Providers in connection with the service provided in Section 13.2 when the Qualified Individual participates in one of the programs described in this section. However, if the Qualified Individual's Evidence of Coverage is compatible with a federally-qualified Health Savings Account, then the Qualified Individual will be responsible for any associated costs for Covered Services provided when the Qualified Individual participates in one of these programs until the annual Deductible has been met.

B. Deductibles, Copayments and Coinsurance will only be waived for services rendered by Designated Providers. However, those services specifically outlined in a Qualified Individual's Home-Based Care Management Plan under provision 13.2F which are not rendered by a Designated Provider are eligiblefor the waiver.

13.4 Termination of the Chronic Care Coordination Program, Complex Case Management, Comprehensive Medication Review, Enhanced Monitoring Program, and Home-Based Services Program.

A. The Qualified Individual's participation in the CCP, CCM, CMR, EMP or HBS will be terminated under the following circumstances:

1. Upon completion of the stated goals of the CCP, CCM, CMR, EMP, or HBS as stated in the Care Plan or Home-Based Care Management Plan and confirmed by the Qualified Individual's treating physician or nurse practitioner, the applicable

program will be terminated and the Qualified Individual will no longer be eligible for benefits under the terminated program.

2. When the Qualified Individual fails to comply with the treatment plan of the CCP, CCM, CMR, or EMP or the Home-Based Care Management Plan of the HBS as determined by the CCC, CCM, HCC, LCC and/or SCM, as applicable, and the determination is approved by the Qualified Individual's treating physician or nurse practitioner.

3. Termination of the coverage of the Qualified Individual under the Evidence of Coverage.

B. The Qualified Individual will be given written notice thirty (30) days in advance of the termination date. If termination of the CCP, CCM, CMR, EMP, or HBS is the result of the Qualified Individual's failure to comply with the CCP, CCM, CMR, EMP, or HBS, the Qualified Individual will be provided the opportunity to comply with the CCP, CCM, CMR, EMP, or HBS during the thirty (30) days prior to the termination of the applicable program(s).

If after continued non-compliance during the thirty (30) day period and a consultation between the Qualified Individual's treating physician or nurse practitioner and the CCC, HCC, LCC and/or SCM, a determination is made that the Qualified Individual is not and will not be compliant with the applicable program(s), the Qualified Individual will receive a final written notice of termination of the applicable program(s).

C. Upon termination of the applicable program(s), the provisions stated in Section 13.3 will be null and void and the Qualified Individual's cost-sharing responsibilities will be as stated in the Schedule of Benefits. This includes the Qualified Individual's cost-sharing responsibilities for services provided in the home under the EMP and HBS.

13.5 Exclusions and Limitations. Coverage will not be provided for the services listed in this section when rendered by non-Designated Providers unless the service is provided pursuant to a Home-Based Care Management Plan under provision 13.2F.]

SECTION 14
GENERAL PROVISIONS

Variation #1

[14.1 How the Plan Works

The Preferred Provider Plan offers two (2) levels of benefits. Members may select the benefit level at which coverage will be provided each time care is sought. Under the Preferred Provider Plan, Members may receive benefits for a particular service under either the In-Network component or the Out-of-Network component. Members may not receive duplicate benefits for the same services.

A. In-Network Benefits

When In-Network benefits apply, Members are eligible for a higher level of benefits than when Out-of-Network benefits apply. In-Network benefits apply in the following circumstances:

1. Services Rendered by a Preferred Provider

Benefits for services rendered by a Preferred Provider are based on the appropriate Allowed Benefit, as described in the [Evidence of Coverage; Agreement]. The level of benefits is reflected under In-Network Benefits in the Schedule of Benefits. Preferred Providers will submit claims to CareFirst directly for Covered Services. The Preferred Provider will accept the Allowed Benefit as full payment for Covered Services.

2. Other Circumstances

In each of the following circumstances, benefits will be based on the appropriate Allowed Benefit for the service or supply provided. The level of benefits for these providers' services will be that shown under In-Network Benefits in the Schedule of Benefits. The Member may be responsible for amounts in excess of the Allowed Benefit, in addition to any applicable Deductibles, Coinsurance, and Copayments.

a. The Member's Preferred Provider refers the Member to a provider who is not a Preferred Provider.

b. The Member receives covered Emergency Services (as defined in the [Evidence of Coverage; Agreement]) from a provider who is not a Preferred Provider.

c. A Preferred Provider is not reasonably available.

B. Out-of-Network Benefits

Out-of-Network benefits apply when Covered Services are provided by a provider who is not a Preferred Provider or in a circumstance not addressed in Section A. When Out-of-Network benefits apply, covered services may be eligible for reduced benefits. When a Member uses a provider that is not a Preferred Provider, benefits are based on the appropriate Allowed Benefit. The level of Out-of-Network Benefits is shown in the Schedule of Benefits. The Member may be responsible for amounts in excess of the Allowed Benefit for services by a provider who is not a Preferred Provider**.]**

Variation #2

[14.1. How the Plan Works

Benefits will be provided when Covered Services are provided by a Participating or Non-Participating Provider. When the Member uses a Participating or Non-Participating Provider, benefits are based on the appropriate Allowed Benefit. The Allowed Benefit for a Non-Participating Provider may be substantially less than the provider's actual charge to the Member.

Non-Participating Providers are not required to accept the Allowed Benefit as full payment and will collect additional amounts from the Member up to the provider's actual charge. Non-Participating Providers will also collect from the Member any applicable Deductibles, Copayment and Coinsurance as well as any charges for non-Covered Services.

[A. Participating Provider
Participating Providers will bill CareFirst directly for Covered Services. The Member will not be responsible for amounts in excess of the Allowed Benefit for Covered Services, except any applicable Copayments, Coinsurance and Deductibles. When Covered Services are rendered inside the Service Area, the Participating Provider will make arrangements with CareFirst to obtain utilization management authorizations and approvals required for coverage. When Covered Services are rendered outside of the service area by Participating Providers, the Member will be responsible for making arrangements with CareFirst to obtain utilization management authorizations and approvals required for coverage.

B. Non-Participating Provider
Non-Participating Providers are not required to accept the Allowed Benefit as full payment and will collect additional amounts from the Member up to the provider's actual charge. The Allowed Benefit may be substantially less than the provider's actual charge to the Member. Therefore, when Covered Services are provided by Non-Participating Providers, Members should expect to pay additional amounts to providers that exceed the Allowed Benefit.]

A Non-Participating Provider may contract with the Member for a different payment amount. However, such provider may not seek payment from CareFirst for these services. In this instance, the Member must submit the claim and payment, not to exceed the Allowed Benefit, will be made to the Member. When benefits are paid to the Member, it is the Member's responsibility to apply any CareFirst payments to the claim from the Non-Participating Provider.

14.2. Member Responsibilities

A. Members are required to submit claims for Covered Services rendered by [Non-Participating] Providers to receive benefits. Members may have claims submitted by the [Non-Participating] Provider on their behalf. A claim submitted by a [Non-Participating] Provider on behalf of a Member must be submitted within the time frame granted to the Member to file the claim. Refer to the Out-of-Network [Evidence of Coverage; Agreement] for claims submission requirements.

B. Members are responsible for providing all information requested by CareFirst with respect to claims for Covered Services provided by [Non-Participating] Providers, including, but not limited to, medical records.

C. Members are responsible for making arrangements with CareFirst to obtain utilization management authorizations and approvals required for Covered Services received from [Non-Participating] Providers. See Section 15, Utilization Management, for the services that require prior authorization.

14.3 Coverage for Services Rendered Outside of the Service Area

[Benefits will be provided for Covered Services rendered outside of the Service Area. All Covered Services rendered outside of the service area will be covered, except Emergency Services, Urgent Care, and follow-up care after emergency surgery which will be covered as In-Network services. See the [Inter-Plan Arrangements Disclosure Amendment] attached to the Out-of-Network Evidence of Coverage for additional information.]

[Benefits will be provided for Covered Services rendered outside of the Service Area. All Covered Services rendered outside of the service area will be covered, except Emergency Services, Urgent Care, and follow-up care after emergency surgery which will be covered as In-Network services. See the [Inter-Plan Arrangements Disclosure Amendment] attached to the Out-of-Network [Evidence of Coverage; Agreement] for additional information.]

When Covered Services are rendered outside of the service area, the Member will be responsible for making arrangements with CareFirst to obtain utilization management authorizations and approvals required for coverage. See Section 15, Utilization Management, for the services that require prior authorization.**]**

Variation # 3

[14.1 Benefits Under this Out-of-Network Point of Service Plan

A. Services Rendered by a Participating Provider
Benefits for services rendered by a Participating Provider are based on the appropriate Allowed Benefit, as described in the Evidence of Coverage. Participating Providers will submit claims to CareFirst directly for Covered Services. The Participating Provider will accept one hundred percent (100%) of the Allowed Benefit as full payment for Covered Services.

B. Services Rendered by a Non-Participating Provider
Benefits will be calculated in the same manner as for a Participating Provider, except that in some instances we are able to negotiate a lower rate with an Eligible Provider. Where CareFirst has negotiated a lower rate, the CareFirst payment will be based on the negotiated amount and the Member will be responsible for all Deductibles and Copayments and Coinsurance as described in the Schedule of Benefits. Where CareFirst has not negotiated a lower rate, the Non-Participating Provider is not required to accept the CareFirst Allowed Benefit as payment in full and may bill the Member directly for any balance above the Allowed Benefit. The Member is responsible for the difference between the Allowed Benefit and the Non-Participating Provider's total charge. The Non-Participating Provider may bill the Member directly. It is the Member's responsibility to apply any payments by CareFirst to a claim from the Non-Participating Provider**.]**

14.[2] Limitation on Provider Coverage
The provider must be licensed, or otherwise authorized by law, in the jurisdiction where the services are rendered. In addition, to be covered, the services must be within the lawful scope of the services for which that provider is licensed or otherwise authorized by law. Coverage does not include services rendered to Members by:

A. The Member him/herself, or by the Member's Spouse, mother, father, daughter, son, brother, or sister; or,

B. Anyone who resides in the Member's home.

14.[3] [Adult Vision Coverage

1. When the Member receives a vision examination from a Contracting Vision Provider, the benefit payment is accepted as payment in full.

2. When the Member receives a vision examination from a Non-Contracting Vision Provider, the Member is responsible for the cost difference between the Vision Care Designee's payment and the Non-Contracting Vision Provider's actual charge. The Vision Care Designee's payment is stated in the Schedule of Benefits.

3. Limited Access Area. If the Member resides in an area that does not have adequate access to a Contracting Vision Provider and the Member receives Vision Care from a

Non-Contracting Vision Provider, the Vision Care Designee will pay up to 100% of the Allowed Benefit. The Member is responsible for any difference between the amount billed and the Vision Care Designee's payment. To determine if the Member resides in a limited access area, the Member must call the Vision Care Designee at the telephone number on the Member's identification card.]

14.[4] Pediatric Vision Coverage.

A. When the Member receives a vision examination from a Contracting Vision Provider, the benefit payment is accepted as payment in full.

B. When a Member receives frames and spectacle lenses or contact lenses from a Contracting Vision Provider, the Member's responsibility is as stated below. The benefit payment is as stated in the attached [Out-of-Network] Schedule of Benefits.

1. When the Member receives frames from the display of collection frames (the collection designated by the Vision Care Designee) and basic spectacle lenses from a Contracting Vision Provider, the benefit payment is accepted as payment in full.

2. When the Member receives other frames, non-basic spectacle lenses or contact lenses from a Contracting Vision Provider, the Member is responsible for the cost difference between the Vision Care Designee's payment and the Contracting Vision Provider's actual charge.

C. When the Member receives Covered Vision Services from a Non-Contracting Vision Provider, the Member is responsible for the cost difference between the Vision Care Designee's payment and the Non-Contracting Vision Provider's actual charge. The Vision Care Designee's payment is stated in the Schedule of Benefits.

D. Limited Access Area: If the Member resides in an area that does not have adequate access to a Contracting Vision Provider and the Member receives Vision Care from a Non-Contracting Vision Provider, the Vision Care Designee will pay up to 100% of the Allowed Benefit. The Member is responsible for any difference between the amount billed and the Vision Care Designee's payment. To determine if the Member resides in a limited access area, the Member must call the Vision Care Designee at the telephone number on the Member's identification card.

14.[5] Pediatric Dental Coverage

A. The Member has the exclusive right to choose a Dentist. Whether a Dentist is a Preferred or Participating Dentist or not relates only to method of payment, and does not imply that any Dentist is more or less qualified than another.

B. CareFirst makes payment for Covered Dental Services, but does not provide these services. CareFirst is not liable for any act or omission of any Dentist.

C. Services of Participating Dentists

1. Claims will be submitted directly to CareFirst by the Dentist.

2. CareFirst will pay benefits directly to the Dentist.

3. The Member is responsible for only the Deductible and Coinsurance.

D. Services of Non-Participating Dentists

1. Claims may be submitted directly to CareFirst by the Non-Participating Dentist

or the Member. In either case, it is the responsibility of the Member to make sure that proof of loss is filed on time as stated in the Proof of Loss section of the Evidence of Coverage.

2. All benefits for Covered Dental Services rendered by a Non-Participating Dentist will be payable to the Subscriber or to the Non-Participating Dentist, at the discretion of CareFirst.

3. The Member is responsible for the difference between the CareFirst payment and the Non-Participating Dentist's charge.

E. Services of Preferred Dentists

1. Many Participating Dentists have special agreements with CareFirst and are part of a network of Preferred Dentists. In general, if a Member chooses a Preferred Dentist, the cost to the Member is lower than if the Member chooses a Non-Preferred Dentist. In the Schedule of Benefits, the Coinsurance percentages are listed as either "In-Network" (for a Preferred Dentist) or "Out-of-Network" (for a Non-Preferred Dentist).

2. If a Preferred Dentist is not reasonably available when a Member requires emergency care (Palliative Treatment and/or Emergency Oral Exam), benefits will be paid based on the "In-Network" Coinsurance percentage listed in the Schedules of Benefits. Participating Dentists will accept the Allowed Benefit as payment in full, except for any applicable Deductible and Coinsurance amounts for which the Member is responsible. Non-Participating Dentists may bill the Member for the difference between the CareFirst payment and the Non-Participating Dentist's charge.

F. Estimate of Eligible Benefits

A Dentist may propose a planned dental treatment or series of dental procedures. A Member may choose to obtain a written estimate of the benefits available for such procedures.

CareFirst encourages a Member to obtain a written Estimate of Eligible Benefits (CareFirst's written estimate of benefits before a service is rendered) also known as a pre-treatment estimate (PTE) for major dental procedures, thereby alerting a Member of the out-of-pocket expenses that may be associated with the treatment plan, related deductibles, co-insurance and/or procedures that are not Covered Dental Services. Based on an Estimate of Eligible Benefits or PTE from CareFirst, a Member can decide whether or not to incur the expense that may be associated with a particular treatment plan.

Failure to obtain an Estimate of Eligible Benefits or PTE has no effect on the benefits to which a Member is entitled. A Member may choose to forgo the Estimate of Eligible Benefits or PTE and proceed with treatment.

After the services are rendered, the claim will be reviewed by CareFirst. Should the review determine that the service(s) rendered meet CareFirst's criteria for benefits, the benefits will be provided as described in this Description of Covered Services. However, should the review of the claim determine that the treatment or procedures did not meet CareFirst's criteria for benefits, benefits will not be provided.

To request an Estimate of Eligible Benefits or PTE prior to receiving dental treatment or dental procedures, a Member should contact his or her Dentist who will coordinate the request on the Member's behalf. If the Dentist has any questions about the process, he or she may contact the CareFirst Provider Services Department or go to the CareFirst website at www.carefirst.com, which lists information in the Physicians and Providers

section, under the subsection for Dental, and list of Resources. The Estimate of Eligible Benefits or PTE is merely an estimate, and it cannot be considered a guarantee of the Member's benefits or enrollment.

The process is different for orthodontic services. The Affordable Care Act requires that orthodontics must be Medically Necessary to be Covered Dental Services. To request a PTE for orthodontic services, the Member must see an orthodontist who will do an exam and orthodontic assessment that may include taking orthodontic records (study models and certain x-rays). The orthodontist will then complete a case assessment using a scoring tool required by the state. Then the orthodontic records and case assessment will be sent to CareFirst for evaluation and confirmation of the assessment score. If the score meets or exceeds the baseline requirement, the orthodontics will be approved for the Member. If the score is less than the minimal required score, then the request for orthodontic benefits will be denied.

A decision by CareFirst to deny benefits as described in this section constitutes an Adverse Decision if the decision is based on a finding that the proposed service is not Medically Necessary, appropriate, or efficient.

[14.[6] Prescription Drug Coverage

A. Accessing the Prescription Drug Benefit Card Program.

1. Members may use his/her identification card to purchase Prescription Drugs from Contracting Pharmacy Providers. If the Prescription Drug coverage includes a Deductible, the Member must pay the entire cost of the Prescription Drug(s) until the Deductible is satisfied. Once the Deductible, if applicable, has been satisfied, the Member pays the appropriate Copayment or Coinsurance as stated in the Schedule of Benefits.

2. For Prescription Drugs or diabetic supplies purchased from a non-Contracting Pharmacy Provider, the Member is responsible for paying the total charge and submitting a claim to CareFirst or its designee for reimbursement. Members will be entitled to reimbursement from CareFirst or its designee up to the amount of the Prescription Drug Allowed Benefit, minus any applicable Deductible, Copayment, or Coinsurance.

3. Members have the option of ordering Prescription Drugs via mail order. The mail order program provides its Member's with a Pharmacy that has an agreement with CareFirst or its designee, to provide mail service Prescription Drugs in accordance with the terms of this provision. The Member is responsible for any applicable Deductible, Copayment or Coinsurance.

B. Additional Terms and Conditions.

1. Providers must obtain prior authorization by providing information to support Medical Necessity before prescribing any Prescription Drug on the Prior Authorization List. A copy of the Prior Authorization List is available to the Member or provider upon request.

2. Providers may substitute a Generic Drug for a Brand Name Drug. If there is no Generic Drug for the Brand Name Drug the Member shall pay the applicable Copayment as stated in the Schedule of Benefits for Non-Preferred Brand Name Drugs.

3. If a provider prescribes a Non-Preferred Brand Name Drug, and the Member selects the Non-Preferred Brand Name Drug when a Generic Drug is available, the Member shall pay the applicable Copayment as stated in the Schedule of

Benefits plus the difference between the price of the Non-Preferred Brand Name Drug and the Generic Drug.

SECTION 15
UTILIZATION MANAGMENT

Failure to meet the requirements of the utilization management program may result in a reduction or denial of benefits even if the services are Medically Necessary.

15.1. Utilization Management

Benefits are subject to review and approval under utilization management requirements established by CareFirst. Through utilization management, CareFirst will:

1. Review Member care and evaluate requests for approval of coverage in order to determine the Medical Necessity for the services;

2. Review the appropriateness of the hospital or facility requested; and,

3. Determine the approved length of confinement or course of treatment in accordance with CareFirst established criteria.

In addition, utilization management may include additional aspects such as prior authorization, and/or preadmission testing requirements, concurrent review, and discharge planning.

If coverage is reduced or excluded for failure to comply with utilization management requirements, the reduction or exclusion may be applied to all services related to the treatment, admission, or portion of the admission for which utilization management requirements were not met. The terms that apply to a Member's coverage for failure to comply with utilization management requirements are stated in the Schedule of Benefits.

[15.2 [Participating Provider] [Preferred Provider] Responsibility

[Participating Providers] [Preferred Providers] located in the CareFirst service area are responsible for providing utilization management notices and obtaining necessary utilization management approvals on the Member's behalf. However, the Member must advise the provider that coverage exists under the plan. In addition, the Member must comply with utilization management requirements and determinations. If the [Participating Provider] [Preferred Provider] fails to obtain such prior authorization, the Member will be held harmless.]

15.[3] Member Responsibility

If the Member receives Covered Services outside of the service area, or care is rendered by [a Non-Preferred Provider] [a Non-Participating Provider] [a[n Out-of-Network] [Non-Participating] Provider], the Member is responsible for all utilization management requirements.

It is the Member's responsibility to ensure that providers associated with the Member's care cooperate with utilization management requirements. This includes initial notification in a timely manner, responding to CareFirst inquiries and, if requested, allowing CareFirst representatives to review medical records on-site or in CareFirst offices. If CareFirst is unable to conduct utilization reviews, Member benefits may be reduced or excluded from coverage.

15.[4] Procedures

To initiate utilization management review, the Member may directly contact CareFirst or may arrange to have notification given by a family member or by the provider that is involved in the Member's care. However, these individuals will be deemed to be acting on the Member's behalf. If the Member and/or the Member's representatives fail to contact CareFirst as required, or provide inaccurate or incomplete information, benefits may be reduced or excluded.

Members should share the requirements of this section with family members and other responsible persons who could arrange for care on the Member's behalf in accordance with this section in case the Member is unable to do so when necessary. CareFirst will provide additional information regarding utilization management requirements and procedures, including telephone numbers and hours of operation, at the time of enrollment and at any time upon the Member's

request.

15.[5] Services Subject to Utilization Management
It is the Member's responsibility to obtain prior authorization for the following services when Covered Services are rendered by [[Out-of-Network] [Non-Participating] Providers] [Non-Preferred Providers] [Non-Participating Providers], and for any Covered Services provided outside of the CareFirst service area.

A. Hospital Inpatient Services

All hospitalizations require prior authorization (except for maternity and Emergency admissions as specified). The Member must contact (or have the provider contact CareFirst) at least five (5) business days prior to an elective or scheduled admission to the hospital. If the admission cannot be scheduled in advance because it is not feasible to delay the admission for five (5) business days due to the Member's medical condition, CareFirst must receive notification of the admission as soon as possible but in any event within forty-eight (48) hours following the beginning of the admission or by the end of the first business day following the beginning of the admission, whichever is later.

Emergency Admissions
CareFirst may not render an adverse decision solely because CareFirst was not notified of the emergency admission within the prescribed period of time after that admission if the Member's condition prevented the hospital from determining the Member's insurance status or CareFirst's emergency admission requirements.

B. Inpatient Mental Illness and Alcohol and/or Substance Abuse Services
The Member must contact CareFirst (or have the provider contact CareFirst) at least five (5) business days prior to an elective or scheduled admission. If the admission cannot be scheduled in advance because care is required immediately due to the Member's condition, CareFirst must receive notification of the admission as soon as possible but in any event within forty-eight (48) hours following the beginning of the admission or by the end of the first business day following the beginning of the admission, whichever is later.

For emergency admissions, CareFirst may not render an adverse decision solely because CareFirst was not notified of the emergency admission within the prescribed period of time after that admission if the Member's condition prevented the hospital from determining the Member's insurance status or CareFirst's emergency admission requirements.

C. Organ and Tissue Transplants
Transplants and related services must be coordinated and prior authorization must be obtained from CareFirst. Prior authorization is not required for cornea transplants and kidney transplants. Coverage for related medications is available under Section 11, Prescription Drugs.

[D. [Inpatient] Hospice Care Services

E. Home Health Services

F. Skilled Nursing Facility Services

[G. Outpatient Services at Hospital or Ambulatory Facility]

H. Medical Devices and Supplies
The Member must contact CareFirst prior to the purchase or rental of the following Medical Devices and Supplies to obtain prior authorization of such purchase or rental:

1. Beds – specialty beds such as heavy duty, pediatric, extra wide, and specialty mattresses

2. Prosthetic Devices

3. Microprocessor limbs
   a. Cochlear implants
   b. Speech generating devices

3. Respiratory Devices
   a. Oral airway devices
   b. Apnea monitor

4. Mobility Devices, Wheelchairs (power and/or custom), and Power Operated Vehicles

5. Phototherapy Devices

6. Specialty Medical Devices and Equipment
   a. defibrillators
   b. wound therapy electrical pumps
   c. hair prosthesis

7. Repairs of Durable Medical Equipment

CareFirst will determine the Medical Necessity for the covered Medical Devices and Supplies and the appropriateness of the type of appliance, device, equipment or supply requested. Failure to contact CareFirst in advance of the purchase or rental and/or failure and refusal to comply with the authorization given by CareFirst may result in reduction or denial of coverage for the Medical Device or Supply.]

Covered Services not listed in this provision do not require prior authorization. CareFirst reserves the right to make changes to the categories of services that are subject to utilization management requirements or to the procedures the Member and/or the providers must follow. CareFirst will notify the Member of these changes at least forty-five (45) days in advance.

Prior authorization is not required for any Covered Services when Medicare is the primary insurer.

15.[6] CareFirst Personnel Availability for Prior Authorization
CareFirst will have personnel available to provide prior authorization at all times when prior authorization is required.

15.[7] Concurrent Review and Discharge Planning. Following timely notification, CareFirst will instruct the Member or the Member's representative, as applicable, about the procedures to follow, including the need to submit additional information and any requirements for re-notification during the course of treatment.

15.[8] Appealing a Utilization Management Decision
If the Member, the Member's representative or Member's provider disagrees with a utilization management decision, CareFirst will review the decision upon request. A utilization management appeal will be reviewed and decided upon by the CareFirst Medical Director or Associate Medical Director not involved in the initial denial decision. If necessary, the Medical Director or Associate Medical Director will discuss the Member's case with the Member's physician and/or request the opinion of a specialist board certified in the same specialty as the treatment under review. Any non-certification or penalty may be appealed. Additional information is provided in the Benefit

Determination and Appeals section of the [Out-of-Network] [Evidence of Coverage; Agreement] on how to appeal a utilization management decision.

[SECTION 16
WELLNESS CREDIT PROGRAM

16.1 Wellness Credit Program

Except for Members under the age of two (2), coverage includes a wellness credit program which rewards Members for healthy behavior. Children under two (2) years of age are not eligible to qualify for the wellness credit. The wellness credit benefit and maximum amounts are stated in the attached Schedule of Benefits.

A. The following participation requirements must be completed by each Member in order to qualify for the wellness credit:

1. Selection of a Primary Care Physician by eligible Members.

2. Completion of a health and wellness evaluation form by a Primary Care Physician and submission of the evaluation form by the eligible Member to CareFirst.

3. Completion of a health assessment. The health assessment requirement applies to Members age eighteen (18) and older:

a. Completion of a health assessment form by Adult Members; and,

b. Consent for the release of the completed health assessment form to the Member's Primary Care Physician.

B. Conditions and Limitations

1. A child's age will be the age of the child on the date of enrollment (or if a renewal, the renewal effective date).

2. Within one hundred twenty (180) days of enrollment (or if a renewal, within one hundred twenty (180) days of the renewal effective date) the eligible Member must:
   a. Select a Primary Care Physician;
   b. Submit the Member's health and wellness evaluation form completed by the Primary Care Physician to CareFirst; and,
   c. For an Adult Member, complete the health assessment form and consent to its release to the Member's Primary Care Physician.

3. The wellness credit must be used during the Benefit Period in which it is earned.

C. Application of the Wellness Credit

1. Individual Coverage

b. If the Member has incurred claims and met his/her Deductible prior to completion of the participation requirements in Section A, the Member will receive a check in the amount of the wellness credit stated in attached Schedule of Benefits.

c. If the Member has incurred claims and the Deductible has been partially met prior to the completion of the participation requirements in Section A, the wellness credit stated in the attached Schedule of Benefits will be applied to the remainder of the Deductible and the Member will receive a check in the amount of the balance, if any, of the wellness credit.

2. Family Coverage

   b. If the family has incurred claims and met the Family Deductible prior to completion of the participation requirements in Section A, the Subscriber will receive a check in the amount of the wellness credit up to the maximum credit amount stated in the attached Schedule of Benefits.

   c. If the family has incurred claims and the Family Deductible has been partially met prior to the completion of the participation requirements in Section A, the wellness credit up to the maximum stated in the attached Schedule of Benefits will be applied to the remainder of the Deductible and the Subscriber will receive a check in the amount of the balance of the wellness credit.

3. Any unused portion of the wellness credit may not be carried over to the next Benefit Period.]

SECTION [17]
EXCLUSIONS AND LIMITATIONS

[17.1] General Exclusions
Coverage is not provided for:

A. Any services, tests, procedures, or supplies which CareFirst determines are not necessary for the prevention, diagnosis, or treatment of the Member's illness, injury, or condition. Although a service or supply may be listed as covered, benefits will be provided only if it is Medically Necessary and appropriate in the Member's particular case.

B. Any treatment, procedure, facility, equipment, drug, drug usage, device, or supply which is Experimental/Investigational, or not in accordance with accepted medical or psychiatric practices and standards in effect at the time of treatment, except for covered benefits for clinical trials.

C. The cost of services that:

1. Are furnished without charge; or

2. Are normally furnished without charge to persons without health insurance coverage; or

3. Would have been furnished without charge if a Member were not covered under the [Evidence of Coverage; Agreement] or under any health insurance.

This exclusion does not apply to:

a) Medicaid;

b) 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.

D. Any service, supply, drug or procedure that is not specifically listed in the Member's [Out-of-Network] [Evidence of Coverage; Agreement] as a covered benefit or that do not meet all other conditions and criteria for coverage at the discretion of CareFirst. Provision of services by a health care provider does not, by itself, entitle a Member to benefits if the services are not covered or do not otherwise meet the conditions and criteria for coverage.

E. Routine, palliative, or Cosmetic foot care (except for conditions determined to be Medically Necessary at the discretion of CareFirst), including flat foot conditions, supportive devices for the foot, treatment of subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toe nails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet.

F. [Routine eye examinations and vision services. This exclusion does not apply to evidence-informed preventive care and screenings, including vision care, provided for in the comprehensive guidelines supported by the Health Resources and Services Administration for infants, children, and adolescents and as stated in Section 3.]

G. Any type of dental care (except treatment of accidental bodily injuries, oral surgery, cleft lip or cleft palate or both, and pediatric dental services), including extractions, treatment of cavities, care of the gums or bones supporting the teeth, treatment of periodontal abscess and periodontal disease, removal of teeth, orthodontics, replacement of teeth, or any other dental services or supplies. Benefits for accidental bodily injury are described in Section 1.16. Benefits for oral surgery are described in Section 1.17. Benefits for treatment of cleft lip, cleft palate or both are described in Section 1.18. Benefits for pediatric dental services

are described in Section 2. All other procedures involving the teeth or areas and structures surrounding and/or supporting the teeth, including surgically altering the mandible or maxillae (orthognathic surgery) for Cosmetic purposes or for correction of malocclusion unrelated to a documented functional impairment are excluded.

H. Cosmetic surgery (except benefits for reconstructive breast surgery or reconstructive surgery) or other services primarily intended to correct, change, or improve appearances. Cosmetic means a service or supply which is provided with the primary intent of improving appearances and not for the purpose of restoring bodily function or correcting deformity resulting from disease, trauma, or previous therapeutic intervention as determined by CareFirst.

I. Treatment rendered by a health care provider who is the Member's Spouse, parent, child, grandparent, grandchild, sister, brother, great grandparent, great grandchild, aunt, uncle, niece, or nephew, or resides in the Member's home.

J. All non-Prescription Drugs, medications, biologicals, and Over-the-Counter disposable supplies, routinely obtained without a prescription and self-administered by the Member, except as listed as a Covered Service above, including but not limited to: cosmetics or health and beauty aids, 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, except for Over-the-Counter medication or supplies dispensed under a written prescription by a health care provider that is identified in the current recommendations of the United States Preventive Services Task Force that have in effect a rating of "A" or "B".

K. Foods or formulas consumed as a sole source of supplemental nutrition, except as listed as a Covered Service in this Description of Covered Services.

L. All assisted reproductive technologies including artificial insemination and intrauterine insemination, in vitro fertilization, gamete intra-fallopian tube transfer, zygote intra-fallopian transfer cryogenic preservation or storage of eggs and embryo and related evaluative procedures, drugs, diagnostic services and medical preparations related to the same.

M. Treatment of sexual dysfunctions or inadequacies including, but not limited to, surgical implants for impotence, medical therapy, and psychiatric treatment.

N. Fees and charges relating to fitness programs, weight loss, or weight control programs, physical or other programs involving such aspects as exercise, physical conditioning, use of passive or patient-activated exercise equipment or facilities and self-care or self-help training or education, except for diabetes outpatient self-management training and educational services. Cardiac Rehabilitation and pulmonary rehabilitation programs are covered as described in Section 1.

O. Maintenance programs for Physical Therapy, Speech Therapy, and Occupational Therapy for those services as stated in Section 1.7; and Cardiac Rehabilitation and pulmonary rehabilitation as stated in Section 1.10D and E.

P. Medical or surgical treatment for obesity, weight reduction, dietary control or commercial weight loss programs, including morbid obesity. This exclusion does not apply to:

1. Well child care visits for obesity evaluation and management;

2. Evidence-based items or services for preventive care and screening for obesity that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF);

3. For infants, children, and adolescents, evidence-informed preventive care and screening for obesity provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;

4. Office visits for the treatment of childhood obesity; and

5. Professional Nutritional Counseling and Medical Nutrition Therapy as described in this Description of Covered Services.

Q. Medical or surgical treatment of myopia or hyperopia, including radial keratotomy and other forms of refractive keratoplasty or any complications thereof.

R. Services that are beyond the scope of the license of the provider performing the service.

S. Services that are solely based on court order or as a condition of parole or probation, unless approved by CareFirst.

T. Health education classes and self-help programs, other than birthing classes or those for the treatment of diabetes.

U. Acupuncture services, except when approved or authorized by CareFirst when used for anesthesia.

V. Any service related to recreational activities. This includes, but is not limited to, sports, games, equestrian, and athletic training. These services are not covered unless authorized or approved by CareFirst even though they may have therapeutic value or be provided by a health care provider.

W. Services or supplies for injuries or diseases related to a covered person's job to the extent the covered person is required to be covered by a workers compensation law.

X. Private duty nursing.

Y. Non-medical services. including, but is not limited to:

1. Telephone consultations, failure to keep a scheduled visit, completion of forms (except for forms that may be required by CareFirst), copying charges or other administrative services provided by the health care provider or the health care provider's staff.

2. Administrative fees charged by a physician or medical practice to a Member to retain the physician's or medical practices services, e.g., "concierge fees" or boutique medical practice membership fees. Benefits under the [Evidence of Coverage; Agreement] are available for Covered Services rendered to the Member by a health care provider.

Z. Rehabilitation services, including Speech Therapy, Occupational Therapy, or Physical Therapy, for conditions not subject to improvement.

AA. Non-medical Ancillary Services such as vocational rehabilitation, employment counseling, or educational therapy.

BB. Services or supplies resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy, excluding no fault insurance.

CC. Transportation and travel expenses (except for Medically Necessary air and ground ambulance services, at the discretion of CareFirst, and services listed under Section 1.12,

Organ and Tissue Transplants, of this Description of Covered Services), whether or not recommended by a health care provider.

DD. Services or supplies received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar persons or groups.

EE. Services, drugs, or supplies the Member receives without charge while in active military service.

FF. Habilitative Services delivered through early intervention and school services.

GG. Custodial Care.

HH. Services or supplies received before the Effective Date of the Member's coverage under the [Evidence of Coverage; Agreement].

II. Durable Medical Equipment or Medical Supplies associated or used in conjunction with non-covered items or services.

JJ. Services required solely for employment, insurance, foreign travel, school, camp admissions or participation in sports activities.

KK. Work Hardening Programs. Work Hardening Program means a highly specialized rehabilitation program designed to simulate workplace activities and surroundings in a monitored environment with the goal of conditioning the participant for a return to work.

LL. Chiropractic services or spinal manipulation treatment other than spinal manipulation treatment for musculoskeletal conditions of the spine.

MM. Any illness or injury caused by war (a conflict between nation states), declared or undeclared, including armed aggression.

[17.2] Pediatric Dental Services

A. Limitations

1. Covered Dental Services must be performed by or under the supervision of a Dentist with an active and unrestricted license, within the scope of practice for which licensure or certification has been obtained.

2. Benefits will be limited to standard procedures and will not be provided for personalized restorations or specialized techniques in the construction of dentures including precision attachments and custom denture teeth.

3. If a Member switches from one Dentist to another during a course of treatment, or if more than one Dentist renders services for one dental procedure, CareFirst shall pay as if only one Dentist rendered the service.

4. CareFirst will reimburse only after all dental procedures for the condition being treated have been completed (this provision does not apply to orthodontic services).

5. In the event there are alternative dental procedures that meet generally accepted standards of professional dental care for a Member's condition, benefits will be based upon the lowest cost alternative procedure.

B. Exclusions
Benefits will not be provided for:

1. Replacement of a denture or crown as a result of loss or theft.

2. Replacement of an existing denture or crown that is determined by CareFirst to be satisfactory or repairable.

3. Replacement of dentures, implants, metal and/or porcelain crowns, inlays, onlays, pontics and crown build-ups within 60 months from the date of placement or replacement for which benefits were paid in whole or in part under the terms of this Description of Covered Services and are judged by CareFirst to be adequate and functional.

4. Gold foil fillings.

5. Periodontal appliances.

6. Oral orthotic appliances, unless specifically listed as a Covered Dental Service.

7. Bacteriologic studies, histopathologic exams, accession of tissue, caries susceptibility tests, diagnostic radiographs, and other pathology procedures, unless specifically listed as a Covered Dental Service.

8. Intentional tooth reimplantation or transplantation.

9. Interim prosthetic devices, fixed or removable and not part of a permanent or restorative prosthetic service.

10. Additional fees charged for visits by a Dentist to the Member's home, to a hospital, to a nursing home, or for office visits after the Dentist's standard office hours. CareFirst shall provide the benefits for the dental service as if the visit was rendered in the Dentist’s office during normal office hours.

11. Transseptal fiberotomy.

12. Orthognathic Surgery.

13. The repair or replacement of any orthodontic appliance, unless specifically listed as a Covered Dental Service.

14. Any orthodontic services after the last day of the month in which Covered Dental Services ended.

15. Separate billings for dental care services or supplies furnished by an employee of a Dentist which are normally included in the Dentist’s charges and billed for by them.

16. Transitional orthodontic appliance, including a lower lingual holding arch placed where there is not premature loss of the primary molar.

17. Limited or complete occlusal adjustments in connection with periodontal surgical treatment when received in conjunction with restorative service on the same date of service.

18. Provision splinting, intracoronal and extracoronal.

19. Endodontic implant.

20. Fabrication of athletic mouthguard.

21. Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth.

22. Adjustments to maxillofacial prosthetic appliance.

23. Maintenance and cleaning of a maxillofacial prosthesis (extra or intraoral).

24. Any orthodontic services after the last day of the calendar year in which the Member turned age 19.

25. Bridges and recementation of bridges.

[17.3] Pediatric Vision Services
Benefits will not be provided for the following:

A. Any pediatric vision service stated in Section 3 for Members over age 19. If Member is under age 19 at the start of the Benefit Period but turns 19 during the Benefit Period, then the Member will receive covered pediatric vision services through the rest of that Calendar Year.

B. Diagnostic services, except as listed in Section 3.

C. Services or supplies not specifically approved by the Vision Care Designee where required in this Description of Covered Services.

D. Orthoptics, vision training, and low vision aids.

E. Non-prescription (Plano) lenses and/or glasses, sunglasses or contact lenses.

F. Except as otherwise provided, Vision Care services that are strictly Cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;

G. Services and materials not meeting accepted standards of optometric practice.

H. Services and materials resulting from the Member's failure to comply with professionally prescribed treatment.

I. Office infection control charges.

J. State or territorial taxes on vision services performed.

K. Special lens designs or coatings other than those described herein.

L. Replacement of lost and/or stolen eyewear.

M. Two pairs of eyeglasses in lieu of bifocals.

N. Insurance of contact lenses.

[17.4] Organ and Tissue Transplants
Benefits will not be provided for the following:

A. Non-human organs and their implantation. This exclusion will not be used to deny Medically Necessary non-Experimental/Investigational skin grafts that are covered under this Description of Covered Services.

B. Any hospital or professional charges related to any accidental injury or medical condition of the donor of the transplant material.

C. Any charges related to transportation, lodging, and meals unless authorized or approved by CareFirst.

D. Services for a Member who is an organ donor when the recipient is not a Member.

E. Donor search services.

F. Any service, supply, or device related to a transplant that is not listed as a benefit in this Description of Covered Services.

[17.5] Inpatient Hospital Services
Coverage is not provided (or benefits are reduced, if applicable) for the following:

A. Private room, unless Medically Necessary and/or authorized or approved by CareFirst. If a private room is not authorized or approved, the difference between the charge for the private room and the charge for a semiprivate room will not be covered.

B. Non-medical items and Convenience Items, such as television and phone rentals, guest trays, and laundry charges.

C. Except for covered Emergency Services and maternity care, a health care facility admission or any portion of a health care facility admission (other than Medically Necessary Ancillary Services) that had not been approved by CareFirst, whether or not services are Medically Necessary and/or meet all other conditions for coverage.

D. Private duty nursing.

[17.6] Home Health Care Services
Coverage is not provided for:

A. Custodial Care.

C. Private duty nursing.

[17.7] Hospice Care Services
Benefits will not be provided for the following:

A. Services, visits, medical equipment, or supplies not authorized by CareFirst.

B. Financial and legal counseling.

C. Any services for which a Qualified Hospice Care Program does not customarily charge the patient or his or her family.

D. Reimbursement for volunteer services.

E. Chemotherapy or radiation therapy, unless used for symptom control.

F. Services, visits, medical equipment, or supplies not required to maintain the comfort and manage the pain of the terminally ill Member.

G. Custodial Care, domestic, or housekeeping services.

H. Meals on Wheels or other similar food service arrangements.

I. Rental or purchase of renal dialysis equipment and supplies. Benefits for dialysis equipment and supplies are available in Section 10, Medical Devices and Supplies.

[17.8] Outpatient Mental Health and Substance Abuse
Coverage is not provided for:

A. Services solely on court order or as a condition of parole or probation unless approved or authorized by the CareFirst Medical Director.

B. Intellectual disability, after diagnosis.

C. Psychoanalysis.

[17.9] Inpatient Mental Health and Substance Abuse
Coverage is not provided for:

A. Admissions as a result of a court order or as a condition of parole or probation unless approved or authorized by the CareFirst Medical Director.

B. Custodial Care.

C. Admissions solely for observation or isolation.

[17.10] Medical Devices and Supplies
Benefits will not be provided for purchase, rental, or repair of the following:

A. Convenience Items
Equipment that basically serves comfort or convenience functions or is primarily for the convenience of a person caring for a Member (e.g., an exercycle or other physical fitness equipment, elevators, hoyer lifts, and shower/bath bench).

B. Furniture items, movable objects or accessories that serve as a place upon which to rest (people or things) or in which things are placed or stored (e.g., chair or dresser).

C. Exercise equipment
Any device or object that serves as a means for energetic physical action or exertion in order to train, strengthen, or condition all or part of the human body, (e.g., exercycle or other physical fitness equipment).

D. Institutional equipment
Any device or appliance that is appropriate for use in a medical facility and not appropriate for use in the home (e.g., parallel bars).

E. Environmental control equipment
Equipment that can be used for non-medical purposes, such as air conditioners, humidifiers, or electric air cleaners. These items are not covered even though they may be prescribed, in the individual's case, for a medical reason.

F. Eyeglasses or contact lenses, dental prostheses, appliances, or hearing aids (except as otherwise provided herein for cleft lip or cleft palate or both or as stated in Section 2 and Section 3).

G. Corrective shoes (unless required to be attached to a leg brace), shoe lifts, or special shoe accessories or inserts.

H. Medical equipment/supplies of an expendable nature, except those specifically listed as covered Medical Devices and Supplies in this Description of Covered Services. Non-covered supplies include incontinence pads or ace bandages.

I. Tinnitus maskers.