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

EVIDENCE OF COVERAGE
FOR A QUALIFIED HEALTH PLAN

This Qualified Health Plan is being offered through the SHOP Exchange.

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

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

Members should not rely on any oral description of the plan because the written terms in the Group's plan documents always govern.

CareFirst recommends that the Member familiarizes himself or herself with the CareFirst complaint and appeal procedure, and make use of it before taking any other action.

NOTE: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, CareFirst may deny insurance benefits if false information materially related to a claim was provided by the applicant.

[Group Name: [_____]]

[Group Number: [_____]]

[Product Name: [_____]]

[Group Effective Date: [_____]]

Group Hospitalization and Medical Services, Inc.

[Signature]

_____

[Name]
[Title]

SECTION 1
DEFINITIONS

The underlined terms, when capitalized, are defined as follows:

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

Affordable Care Act means the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111–148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152).

Allowed Benefit means:

A. For a Preferred Provider, the Allowed Benefit for a Covered Service is the amount agreed upon between CareFirst and the Preferred Provider which, in some cases, will be a rate set by a regulatory agency. The benefit is payable to the provider and is accepted as payment in full, except for any applicable Deductible, Copayment, or Coinsurance amounts, for which the Member is responsible.

B. For a Non-Preferred Provider that is a health care practitioner, the Allowed Benefit for a Covered Service is based upon the lesser of the provider's actual charge or the established fee schedule. The benefit is payable to the Member or to the provider at the discretion of CareFirst. The Member is responsible for any applicable Deductible, Copayment, or Coinsurance amounts stated in the Schedule of Benefits and the difference between the Allowed Benefit and the practitioner's actual charge. The provider may bill the Member directly for such amounts. It is the Member's responsibility to apply any CareFirst payments to the claim from the Non-Preferred Provider charge.

C. For a Non-Preferred Provider that is a health care facility, the Allowed Benefit for a Covered Service is based upon either the provider's actual charge or the established fee schedule. The benefit is payable to the Member or to the facility, at the discretion of CareFirst. Benefit payments to Department of Defense and Veteran Affairs providers will be made directly to the provider. The Member is responsible for any applicable Deductible, Copayment, or Coinsurance amounts stated in the Schedule of Benefits and, unless negotiated, for the difference between the Allowed Benefit and the provider's actual charge. It is the Member's responsibility to apply any CareFirst payments to the claim from the Non-Preferred Facility.

   In some cases, and on an individual basis, CareFirst is able to negotiate a lower rate with an eligible provider. In that instance, the CareFirst payment will be based on the negotiated fee and the provider agrees to accept the amount as payment in full except for any applicable Deductible, Copayment, or Coinsurance amounts, for which the Member is responsible.

D. For a Covered Service rendered by a non-preferred ambulance service provider, the Allowed Benefit for a Covered Service is based upon the lesser of the provider's actual charge or the established fee schedule. The benefit is payable to the Member or to the non-preferred ambulance service provider, at the discretion of CareFirst. It is the Member's responsibility to apply any CareFirst payments to the claim from the non-preferred ambulance service provider.

   For Emergency Services provided by a Non-Preferred Provider, the Allowed Benefit for a Covered Service will be no less than the amount specified section 2719A of the Public Health Service Act and the regulations promulgated pursuant thereto.

Pediatric Dental Allowed Benefit means:

A. For Preferred Dentists, the Allowed Benefit payable to a Preferred Dentist for a Covered Dental Service will be the amount agreed upon between CareFirst and the Preferred Dentist. The benefit payment is made directly to the Preferred Dentist and accepted as payment in full, except for any applicable Deductible and Coinsurance for which the Subscriber is responsible as stated in the Schedule of Benefits. The Subscriber is responsible for any applicable Deductible and Coinsurance, and both Preferred and Non-Preferred Dentists may bill the Subscriber directly for such amounts.

B. For Participating Dentists, the Allowed Benefit payable to a Participating Dentist for a Covered Dental Service will be the lesser of (1) the Dentist's actual charge; or (2) the benefit amount, according to the CareFirst rate schedule for the Covered Dental Service that applies on the date the service is rendered. The benefit amount on the CareFirst rate schedule will be no less than the amount paid to a Preferred Dentist in the same geographic area for the same service. The benefit payment is made directly to the Participating Dentist and is accepted as payment in full, except for the Deductible and Coinsurance amounts stated in the Schedule of Benefits. The Subscriber is responsible for any applicable Deductible and Coinsurance and the Participating Dentist may bill the Subscriber directly for such amounts.

C. For Non-Participating Dentists, the Allowed Benefit payable to a Non-Participating Dentist for a Covered Dental Service will be determined in the same manner as the Allowed Benefit payable to a Participating Dentist. For a Non-Participating Dentist who is a physician, the benefit is payable to the physician if the Subscriber has given an Assignment of Benefits or, otherwise, to the Subscriber or the Non-Participating Dentist at the discretion of CareFirst. For any other Non-Participating Dentist, the benefit is payable to the Subscriber or to the Non-Participating Dentist at the discretion of CareFirst. The Subscriber is responsible for payment for services to the Non-Participating Dentist, including any applicable Deductible and Coinsurance amounts as stated in the Schedule of Benefits and for any balance bill amounts. The Non-Participating Dentist may bill the Subscriber directly for such amounts. It is the Subscriber's responsibility to apply any CareFirst payments to the claim from the Non-Participating Dentist.

Pediatric Vision Allowed Benefit means:

A. For a Contracting Vision Provider, the Pediatric Vision Allowed Benefit for a covered service is the lesser of:

1. The actual charge; or

2. The benefit amount, according to the Vision Care Designee's rate schedule for the covered service or supply that applies on the date the service is rendered.

The benefit payment is made directly to a Contracting Vision Provider. When a Member receives Covered Vision Services from a Contracting Vision Provider, the benefit payment is accepted as payment in full, except for any applicable Copayment. When a Member receives frames and spectacle lenses or contact lenses from a Contracting Vision Provider, the benefit payment is as stated in the Schedule of Benefits below. The Contracting Vision Provider may collect any applicable Copayment or amounts in excess of the Vision Care Designee's payment when other frames and non-standard spectacle lenses or other contact lenses are purchased by the Member.

B. For a Non-Contracting Vision Provider, the Allowed Benefit for Vision Care will be determined in the same manner as the Allowed Benefit to a Contracting Vision Provider.

Benefits may be paid to the Subscriber or to the Non-Contracting Vision Provider at the discretion of the Vision Care Designee. 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 Non-Contracting Vision Provider may bill the Member directly. It is the Member's responsibility to apply any CareFirst payments to the claim from the Non-Contracting Vision Provider.

Prescription Drug Allowed Benefit means the lesser of:

A. The Pharmacy's actual charge; or

B. The benefit amount, according to the CareFirst fee schedule, for covered Prescription Drugs that applies on the date the service is rendered.

If the Member purchases a covered Prescription Drug or diabetic supply from a Contracting Pharmacy Provider, the benefit payment is made directly to the Contracting Pharmacy Provider and is accepted as payment in full, except for any applicable Deductible, Copayment, or Coinsurance. The Member is responsible for any applicable Deductible, Copayment, or Coinsurance and the Contracting Pharmacy Provider may bill the Member directly for such amounts.

If the Member purchases a covered Prescription Drug 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 in the amount of the Allowed Benefit, minus any applicable Deductible, Copayment, or Coinsurance. Members may be responsible for balances above the Allowed Benefit.

Annual Open Enrollment Period means the period of no less than thirty (30) days each year prior to the Group's Contract Renewal Date during which an individual may enroll or change coverage in this Qualified Health Plan through the SHOP Exchange.

Benefit Period means, except for the Covered Vision Services described below, the consecutive twelve (12) month period during which coverage is provided for Covered Services, Covered Dental Services, and Covered Vision Services. The annual vision examination may occur at any time during this Benefit Period. For Covered Vision Services other than the annual vision examination, the Benefit Period is 12-months dating from the first Covered Vision Service.

Bereavement Counseling means counseling provided to the Immediate Family or Family Caregiver of the Member after the Member's death to help the Immediate Family or Family Caregiver cope with the death of the Member.

Brand Name Drug means a Prescription Drug that has been given a name by a manufacturer or distributor to distinguish it as produced or sold by a specific manufacturer or distributor and may be used and protected by a trademark.

Calendar Year means January 1 through December 31 of each year.

Cardiac Rehabilitation means inpatient or outpatient services designed to limit the physiologic and psychological effects of cardiac illness, reduce the risk for sudden death or reinfarction, control cardiac symptoms, stabilize or reverse atherosclerotic process, and enhance the psychosocial and vocational status of eligible Members.

CareFirst means Group Hospitalization and Medical Services, Inc., doing business as CareFirst BlueCross BlueShield.

Civil Union means a same-sex relationship similar to marriage that is recognized by law. The Subscriber's partner in a Civil Union is eligible for coverage to the same extent as an eligible Spouse.

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

Contract Renewal Date means the date on which the Group Contract renews and each anniversary of such date.

Contract Year means the twelve (12) month period beginning on the Group Effective Date.

Contracting Pharmacy Provider means a separate independent Pharmacist or Pharmacy that has contracted with CareFirst or its designee to provide covered Prescription Drugs.

Contracting Vision Provider means any optometrist or ophthalmologist licensed as such by the duly constituted authority in the jurisdiction in which Covered Vision Services are rendered when acting within the scope of such license and that has contracted with the Vision Care Designee to provide Covered Vision Services.

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

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

Copayment (Copay) means the fixed dollar amount that a Member must pay for certain Covered Services, Covered Dental Services or Covered Vision Services.
When a Member receives multiple services on the same day by the same health care provider, the Member will only be responsible for one (1) Copay.
The inclusion or exclusion of the italicized text is dependent upon plan design.

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

Covered Dental Services means Medically Necessary services or supplies listed in Section 2 of the Description of Covered Services.

Covered Service means Medically Necessary services or supplies provided in accordance with the terms of this Evidence of Coverage other than Covered Dental Services or Covered Vision Services.

Covered Vision Services means Medically Necessary services or supplies listed in Section 3of the Description of Covered Services.

Custodial Care means care provided primarily to meet the personal needs of the patient. Custodial Care does not require skilled medical or paramedical personnel. Such care includes help in walking, bathing, or dressing. Custodial Care also includes preparing food or special diets, feeding, administering medicine, or any other care not requiring continuing services of medically trained personnel.

Decertification or Decertified means the termination by the SHOP Exchange of the certification and offering of this Qualified Health Plan.

Deductible means the dollar amount of the Allowed Benefits payable during a Benefit Period for Covered Services or Covered Dental Services that must first be incurred by the Member before CareFirst will make payments for Covered Services or Covered Dental Services.

Dental Director is a Dentist appointed by the Medical Director of CareFirst to perform administrative duties with regard to the dental services listed in this Evidence of Coverage.

Dentist means an individual who is licensed to practice dentistry as defined by the respective jurisdiction where the practitioner provides care.

Dependent means a Member who is covered as an eligible Spouse or Dependent Child as defined in Sections 2.2 and 2.3. The eligibility of Dependents to enroll is stated in the Eligibility Schedule.

Dependent Child or Dependent Children means one or more eligible individuals as defined in Section 2.3.

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

Emergency Medical Condition means:

A. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part; or

B. With respect to a pregnant woman who is having contractions: there is inadequate time to effect a safe transfer to another hospital before delivery, or transfer may pose a threat to the health or safety of the woman or the unborn child.

Emergency Services means, with respect to an Emergency Medical Condition:

A. A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and

B. Such further medical examination and treatment, to the extent they are within the capability of the staff and facilities available at the hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)) to Stabilize the Member.

Evidence of Coverage means this agreement, including all duly authorized attachments, notices, amendments and riders, issued to the Group and the Subscriber by CareFirst under the Group Contract between the Group and CareFirst.

Experimental/Investigational means a service or supply in the developmental stage and in the process of human or animal testing excluding patient costs for clinical trials as stated in the Description of Covered Services. Services or supplies that do not meet all five of the criteria listed below are deemed to be Experimental/Investigational:

A. The Technology* must have final approval from the appropriate government regulatory bodies;

B. The scientific evidence must permit conclusions concerning the effect of the Technology on health outcomes;

C. The Technology must improve the net health outcome;

D. The Technology must be as beneficial as any established alternatives; and

E. The improvement must be attainable outside the Investigational settings.

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

FDA means the United States Food and Drug Administration.

Family Caregiver means a relative by blood, marriage, or Adoption who lives with or is the primary Caregiver of the terminally ill Member.

Family Counseling means counseling given to the Immediate Family or Family Caregiver of the terminally ill Member for the purpose of learning to care for the Member and to adjust to the impending death of the Member.

Generic Drug means any Prescription Drug approved by the FDA that has the same bio-equivalency as a specific Brand Name Drug.

Group means the Qualified Employer to which CareFirst has issued the Group Contract and the Evidence of Coverage.

Group Contract means the contract, including all duly authorized attachments, notices, amendments and riders, between the Group and CareFirst.

Group Contract Effective Date means the effective date of the Group Contract.

Habilitative Services means services that help a person 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.

Home Health Care or Home Health Care Services means the continued care and treatment of a Member in the home by a licensed Home Health Agency if:

A. The institutionalization of the Member in a hospital, related institution, or Skilled Nursing Facility would otherwise have been required if Home Health Care Services were not provided; and

B. The Plan of Treatment covering the Home Health Care Service is established and approved in writing by the health care provider, and determined to be Medically Necessary by CareFirst.

Immediate Family means the Spouse, parents, siblings, grandparents, and children of the terminally ill Member.

Limiting Age means the maximum age up to which a Dependent Child may be covered as stated in the Eligibility Schedule.

Low Vision means a significant loss of vision but not total blindness. Ophthalmologists and optometrists specializing in Low Vision care can evaluate and prescribe optical devices, and provide training and instruction to maximize the remaining usable vision for Members with Low Vision.

Maintenance Drug means a Prescription Drug anticipated being required for six (6) months or more to treat a chronic condition.

Mastectomy means the surgical removal of all or part of the breast.

Medical Child Support Order (MCSO) means an order issued in the format prescribed by federal law and issued by an appropriate child support enforcement agency to enforce the health insurance coverage provisions of a child support order. An order means a judgment, decree, or a ruling (including approval of a settlement agreement) that:

A. Is issued by a court or administrative child support enforcement agency of any state or the District of Columbia; and

B. Creates or recognizes the right of a child to receive benefits under a parent's health insurance coverage or establishes a parent's obligation to pay child support and provide health insurance coverage for a child.

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

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

A. In accordance with generally accepted standards of medical practice;

B. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for a patient's illness, injury, or disease;

C. Not primarily for the convenience of a patient or health care provider; and

D. Not more costly than an alternative service or sequence of services that are at least as likely to produce equivalent therapeutic or diagnostic results in the diagnosis or treatment of the patient's illness, injury, or disease.

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

The fact that a health care provider may prescribe, authorize or direct a service does not of itself make it Medically Necessary or covered by the Group Contract.

Medical Nutrition Therapy provided by a licensed dietitian-nutritionist involves the assessment of the Member's overall nutritional status followed by the assignment of an individualized diet, counseling, and/or specialized nutrition therapies to treat a chronic illness or condition. The licensed dietitian-nutritionist, working in a coordinated, multidisciplinary team effort with the Primary Care Physician takes into account a Member's condition, food intake, physical activity, course of any medical therapy, including medications and other treatments, individual preferences, and other factors.

Member means an individual who meets all applicable eligibility requirements of Section 2, is enrolled for coverage and for whom the CareFirst receives the premiums and other required payments. A Member can be either a Subscriber or Dependent.

Minimum Essential Coverage has the meaning given in the Affordable Care Act, 26 U.S.C. §5000A(f).

Non-Contracting Vision Provider means any optometrist or ophthalmologist licensed as such by the duly constituted authority in the jurisdiction in which Covered Vision Services are rendered when acting within the scope of such license; and, who does not have an agreement with the Vision Care Designee for the rendering of Covered Vision Services. A Non-Contracting Vision Provider may or may not have contracted with CareFirst. The Member should contact the Vision Care Designee for the current list of Contracting Vision Providers.

Non-Participating Dentist means any Dentist who, at the time of rendering a Covered Dental Service to the Member, does not have a written agreement with CareFirst or CareFirst's designee for the rendering of such service.

Non-Preferred Dentist means any Dentist who is not a Preferred Dentist, including a Participating Dentist and a Non-Participating Dentist.

Non-Preferred Provider means a health care provider that does not contract with CareFirst to provide Covered Services. Neither Participating Dentists or Non-Participating Dentists who provide Covered Dental Services nor Non-Contracting Vision Providers who provide Covered Vision Services are Non-Preferred Providers for the purposes of this definition.

Out-of-Pocket Maximum means the maximum amount the Member will have to pay for his/her share of benefits in any Benefit Period. The Out-of-Pocket Maximum does not include premiums, the cost of services that are not Covered Services, or any amounts paid to providers in excess of the Allowed Benefit, the Pediatric Dental Allowed Benefit, the Pediatric Vision Allowed Benefit or the Prescription Drug Allowed Benefit. Once the Member meets the Out-of-Pocket Maximum, the Member will no longer be required to pay Copayments, Coinsurance or Deductible for the remainder of the Benefit Period.

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

Participating Dentist means any Dentist who, at the time of rendering a Covered Dental Service to the Member, has a written agreement with CareFirst or CareFirst's designee for the rendering of such service.

Pharmacist means an individual licensed to practice pharmacy regardless of the location where the activities of practice are performed.

Pharmacy means an establishment in which prescription or nonprescription drugs or devices are compounded, dispensed, or distributed.

Preferred Brand Name Drug means a Brand Name Drug that is included on CareFirst's Preferred Drug List.

Preferred Dentist means one of a network of Participating Dentists who, at the time of rendering a Covered Dental Service to the Member, has a written agreement with CareFirst, or CareFirst's designee, for the rendering of such service.

Preferred Drug List means the list of Brand Name Drugs and Generic Drugs issued by CareFirst and used by health care providers when writing, and Pharmacists, when filling, prescriptions. All Generic Drugs are included in the Preferred Drug List. Not all Brand Name Drugs are included in the Preferred Drug List. A copy of the Preferred Drug List is available to the Member upon request.

Preferred Generic Drug means a Generic Drug on the CareFirst Preferred Drug List used for the treatment of diabetes, high cholesterol, high blood pressure (hypertension), depression, or asthma.
The inclusion or exclusion of the italicized text is dependent upon plan design.

Preferred Preventive Drug means a Prescription Drug or Over-the-Counter medication or supply dispensed under a written prescription by a health care provider that is included on the CareFirst Preferred Preventive Drug List.

Preferred Preventive Drug List means a Prescription Drug, including an Over-the-Counter medication or supply dispensed under a written prescription by a health care provider that is included on the list issued by CareFirst of the items identified in the current recommendations of the United States Preventive Services Task Force that have in effect a rating of "A" or "B" or as provided in the comprehensive guidelines for women's preventive health supported by the Health Resources and Services Administration. A copy of the Preferred Preventive Drug List is available to the Member upon request.

Preferred Provider means a health care provider that has contracted with CareFirst to render Covered Services to Members. A Preferred Dentist who provides Covered Dental Services or a Contracting Vision Provider who provides Covered Vision Services is not a Preferred Provider for the purposes of this

definition. Preferred Provider relates only to method of payment, and does not imply that any physician, health care professional or health care facility is more or less qualified than another.

A listing of Preferred Providers will be provided to the Member at the time of enrollment and is also available from CareFirst upon request. The listing of Preferred Providers is subject to change. Members may confirm the status of any health care provider prior to making arrangements to receive care by contacting CareFirst for up-to-date information.

Prescription Drug means:

A. A drug, biological or compounded prescription intended for outpatient use that carries the FDA legend "may not be dispensed without a prescription";

B. Drugs prescribed for treatments other than those stated in the labeling approved by the FDA, if the drug is recognized for such treatment in standard reference compendia or in the standard medical literature as determined by CareFirst;

C. A covered Over-the-Counter medication or supply; or

D. Any diabetic supply.

Primary Care Dependent means an unmarried grandchild, niece or nephew for whom the Subscriber provides primary care including food, shelter and clothing on a regular and continuous basis during the time the District of Columbia public schools are in regular session.

Primary Care Physician (PCP) means a Preferred Provider selected by a Member to provide and manage the Member's health care. PCP means health care practitioners in the following disciplines:

A. General internal medicine;

B. Family practice medicine;

C. Obstetrician/Gynecologist;

D. General pediatric medicine; or

E. Geriatric medicine.

Prior Authorization List means the limited list of Prescription Drugs issued by CareFirst for which providers, when writing, and Pharmacists, when filling prescriptions, must obtain prior authorization from CareFirst. A copy of the Prior Authorization List is available to the Member upon request.

Professional Nutritional Counseling means individualized advice and guidance given to a Member who is at nutritional risk due to nutritional history, current dietary intake, medication use, or chronic illness or condition, about options and methods for improving nutritional status. Professional Nutritional Counseling must be provided by a licensed dietitian-nutritionist, physician, physician assistant, or nurse practitioner.

Qualified Employee means an eligible individual who has been offered health insurance coverage by the Group through the SHOP Exchange. The Group's eligibility requirements for a Qualified Employee are stated in the Eligibility Schedule.

Qualified Employer means the employer that the SHOP Exchange has determined to be qualified to offer Qualified Health Plan(s).

Qualified Health Plan means a health plan certified by the SHOP Exchange as having met the standards established by the U.S. Department of Health and Human Services.

Qualified Home Health Agency means a licensed program approved for participation as a home health agency under Medicare, or certified as a home health agency by the Joint Commission on Accreditation of Healthcare Organizations, its successor, or the applicable state regulatory agency.

Qualified Hospice Care Program means a coordinated, interdisciplinary program provided by a hospital, Qualified Home Health Agency, or other health care facility licensed or certified by the state in which it operates as a hospice program and is designed to meet the special physical, psychological, spiritual, and social needs of terminally ill individuals and their families, by providing palliative and supportive medical, nursing, and other health services through home or inpatient care during the illness and bereavement period. Benefits are available to:

A. Individuals who have no reasonable prospect of cure as estimated by a physician; and

B. The immediate families or Family Caregivers of those individuals.

Qualified Medical Support Order (QMSO) means a Medical Child Support Order, issued under state law or the laws of the District of Columbia, that is issued to an employer sponsored health plan that complies with section 609(A) of the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

Rescind or Rescission means a termination, cancellation or discontinuance of coverage that has retroactive effect. For example, a cancellation that treats coverage as void from the time of the individual's or group's enrollment is a Rescission. As another example, a cancellation that voids benefits paid up to a year before the cancellation is also a Rescission for this purpose. Coverage is not Rescinded and a cancellation or discontinuance of coverage is not a Rescission if:

A. The termination, cancellation or discontinuance of coverage has only a prospective effect; or

B. The termination, cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay charges when due, by the Group.

Respite Care means temporary care provided to the terminally ill Member to relieve the Caregiver/Family Caregiver from the daily care of the Member.

Service Area means the clearly defined geographic area in which CareFirst has arranged for the provision of health care services to be generally available and readily accessible to Members, except for emergency services. CareFirst may amend the defined Service Area at any time by notifying the Group in writing.

The Service Area is as follows: the District of Columbia; the state of Maryland; in the Commonwealth of Virginia, the cities of Alexandria and Fairfax, Arlington County, the town of Vienna and the areas of Fairfax and Prince Williams Counties in Virginia lying east of Route 123.

SHOP Exchange means *the District of Columbia Health Benefit Exchange (DC HBX).*
This variation is to accommodate a change in the name of the Exchange.

Skilled Nursing Facility means a licensed institution (or a distinct part of a hospital) accredited or approved under Medicare or The Joint Commission and provides continuous Skilled Nursing Care and related services for Members who require medical care, Skilled Nursing Care, or rehabilitation services. Inpatient skilled nursing is for patients who are medically fragile with limited endurance and require a licensed health care professional to provide skilled services in order to ensure the safety of the patient and to achieve the medically desired result. Inpatient skilled nursing services must be provided on a 24 hour basis, 7 days a week.

Sound Natural Teeth means teeth restored with intra- or extra-coronal restorations (fillings, inlays, onlays, veneers, and crowns) that are in good condition; absent decay, fracture, bone loss, periodontal disease, root canal pathology or root canal therapy and excludes any tooth replaced by artificial means (implants, fixed or removable bridges, dentures).

Special Enrollment Period means a period during which an eligible individual who experiences certain qualifying events may enroll in, or change enrollment in, a Qualified Health Plan through the SHOP Exchange outside of any Annual Open Enrollment Periods.

Specialist means a licensed health care provider who is certified or trained in a specified field of medicine.

Specialty Drugs means high-cost injectables, infused, oral, or inhaled Prescription Drugs for the ongoing treatment of a chronic condition, including but not limited to, the following: Hemophilia, Hepatitis C, Multiple Sclerosis, Infertility Treatment Management, Rheumatoid Arthritis, Psoriasis, Crohn's Disease, Cancer (oral medications), and Growth Hormones. These Prescription Drugs usually require specialized handling (such as refrigeration).

Spouse means a person of the same or opposite sex who is legally married to the Subscriber under the laws of the state or jurisdiction in which the marriage took place. A marriage legally entered into in another jurisdiction will be recognized as a marriage in the District of Columbia.

Stabilize, in accordance with § 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)), means to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an Emergency Medical Condition described in paragraph B of the above definition, to deliver (including the placenta).

Subscriber means a Member who is enrolled as a Qualified Employee or eligible former Qualified Employee rather than as a Dependent.

Urgent Care means treatment for a condition that is not a threat to life or limb but does require prompt medical attention. Also, the severity of an urgent condition does not necessitate a trip to the hospital emergency room. An Urgent Care facility is a freestanding facility that is not a physician's office and which provides Urgent Care.

Vision Care Designee means the entity with which CareFirst has contracted to administer Vision Care. *CareFirst's Vision Care Designee is Davis Vision, Inc. Davis Vision, Inc. is an independent company and administers the Vision Care benefits on behalf of CareFirst.*

Davis Vision Inc. has been italicized to accommodate changes in CareFirst vendors. The second and third sentences have been italicized to be able to include the name of the CareFirst vendor within the document.

Waiting Period means the period of time, stated in the Eligibility Schedule, that must pass before a Qualified Employee or any Dependent is eligible for coverage under the terms of the Group Contract.

SECTION 2
ELIGIBILITY AND ENROLLMENT

2.1 Requirements for Coverage. To be covered, all of the following conditions must be met:

A. A Subscriber must be an eligible Qualified Employee of the Group. To enroll as a Subscriber, the individual must, at the time of enrollment, meet the eligibility requirements established by the Group. The Group's eligibility requirements for a Qualified Employee are stated in the Eligibility Schedule.

B. Any other Member must be an eligible individual who is a Dependent of a Subscriber. To enroll as a Dependent, the individual must, at the time of enrollment meet the eligibility requirements established by the Group. The eligibility of Dependents to enroll is stated in the Eligibility Schedule.

C. For each Subscriber and Member, the SHOP Exchange must receive premium payments as required by the Group Contract.

2.2 Eligibility of Subscriber's Spouse. If the Group has elected to include coverage for the Subscriber's Spouse, then a Subscriber may enroll a Spouse as a Dependent. A Subscriber cannot cover a former Spouse once divorced or if the marriage had been annulled. Premium changes resulting from the enrollment of a Spouse will be effective as of the Effective Date of the Spouse's enrollment.

2.3 Eligibility of Dependent Children. If the Group has elected to include coverage for Dependent Children of the Subscriber or a Subscriber's covered Spouse, then a Subscriber may enroll one or more Dependent Children. A Dependent Child means an individual who:

A. Is:

1. The natural child, stepchild, or adopted child of the Subscriber;

2. A child placed with the Subscriber or the Subscriber's covered Spouse for legal Adoption;

3. A child under testamentary or court appointed guardianship, other than temporary guardianship for less than twelve (12) months' duration, of the Subscriber or the Subscriber's covered Spouse; or

4. An unmarried grandchild, niece or nephew, who meets the requirements for coverage as the Subscriber's Primary Care Dependent as stated below:

a) The child must be the Subscriber's unmarried grandchild, niece, or nephew;

b) The child is under the Subscriber's Primary Care. Primary Care means the Subscriber provides food, clothing and shelter for the child on a regular and continuous basis during the time District of Columbia public schools are in regular session; and,

c) If the child's legal guardian is someone other than the Subscriber, the child's legal guardian is not covered under any other health insurance policy.

The Subscriber must provide CareFirst with proof upon application that the child meets the requirements for coverage as a Primary Care Dependent, including proof of the child's relationship and primary dependency on the Subscriber and certification that the child's legal guardian does not have other coverage. CareFirst

reserves the right to verify whether the child is and continues to qualify as a Primary Care Dependent, and

B. Is under the Limiting Age as stated in the Eligibility Schedule; or

C. Is a disabled Dependent Child who is older than the Limiting Age and the Subscriber provides proof that: (1) the Dependent Child is incapable of self-support or maintenance because of a mental or physical incapacity; (2) the Dependent Child is primarily dependent upon the Subscriber or the Subscriber's covered Spouse for support and maintenance; and (3) the Dependent Child had been covered under the Subscriber's or the Subscriber's Spouse's prior health insurance coverage since before the onset of the mental or physical incapacity.

D. Is the subject of a Medical Child Support Order (MCSO) or Qualified Medical Support Order (QMSO) that creates or recognizes the right of the child to receive benefits under the health insurance coverage of the Subscriber or the Subscriber's covered Spouse.

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

2.4 Limiting Age for Covered Dependent Children.

A. All covered Dependent Children are eligible for coverage up to the Limiting Age for Dependent Children as stated in the Eligibility Schedule.

B. A Dependent Child covered under this Evidence of Coverage will be eligible for coverage past the Limiting Age if, at the time coverage would otherwise terminate:

1. The Dependent Child is unmarried and is incapable of self-support or maintenance because of a mental or physical incapacity;

2. The Dependent Child is primarily dependent upon the Subscriber or the Subscriber's covered Spouse for support and maintenance;

3. The mental or physical incapacity occurred before the covered Dependent Child reached the Limiting Age; and

4. The Subscriber provides CareFirst with proof of the Dependent Child's mental or physical incapacity within thirty-one (31) days after the Dependent Child reaches the Limiting Age for Dependent Children. CareFirst has the right to verify whether the child is and continues to qualify as an incapacitated Dependent Child.

C. Dependents' coverage will automatically terminate if there is a change in their age, status, or relationship to the Subscriber, such that they no longer meet the eligibility requirements of this Evidence of Coverage or the Eligibility Schedule. Coverage of an ineligible Dependent will terminate as stated in the Eligibility Schedule.

2.5 Open Enrollment Opportunities and Effective Dates. A Qualified Employee may elect coverage for himself or herself or for an eligible Dependent only during the following times and under the following conditions.

A. Annual Open Enrollment. During an Annual Open Enrollment Period, a Qualified Employee or eligible individual may enroll as a Subscriber or Member.

B. Newly Eligible Subscriber. If a Qualified Employee is a new employee or a newly

eligible employee of the Group, the new Qualified Employee may enroll him or herself and any eligible Dependent within [thirty (30)][sixty (60)] days after a new Qualified Employee first becomes eligible. The eligibility requirements for a new Qualified Employee in the Group are stated in the Eligibility Schedule.

C. Special Enrollment. If an eligible individual does not enroll during an Annual Open Enrollment Period or as a newly eligible Qualified Employee, he or she may only enroll through the SHOP Exchange during a Special Enrollment Period:

1. Thirty (30) or Thirty-One (31) Day Special Enrollment Period. An eligible individual may enroll as a Subscriber or Dependent upon the occurrence of one of the following qualifying events:

a) The eligible individual loses Minimum Essential Coverage. A loss of Minimum Essential Coverage includes those circumstances described in 26 CFR 54.9801-6(a)(3)(i) through (iii). A loss of Minimum Essential Coverage does not include:

(1) Failure to pay premiums on a timely basis, including COBRA premiums prior to the expiration of COBRA coverage; or

(2) Situations allowing for a Rescission.

b) A Qualified Employee or an eligible individual gains, or becomes, a Dependent through marriage, birth, Adoption, placement for Adoption, or grant of court or testamentary guardianship.

c) The eligible individual's enrollment in another Qualified Health Plan or non-enrollment is unintentional, inadvertent, or erroneous and is the result of an error, misrepresentation, inaction of an officer, employee, or agent of the SHOP Exchange or the United States Department of Health and Human Services or its instrumentalities as evaluated and determined by the SHOP Exchange.

d) The eligible individual, who is an enrollee in another Qualified Health Plan, demonstrates to the SHOP Exchange that the other Qualified Health Plan in which he or she has enrolled substantially violated a material provision of its contract in relation to the eligible individual.

e) The eligible individual becomes eligible as a result of a permanent move.

f) The eligible individual is an Indian, as defined in section 4 of the Indian Health Care Improvement Act, who may enroll in a Qualified Health Plan or change coverage from one Qualified Health Plan to another one time per month.

g) The eligible individual demonstrates to the SHOP Exchange, in accordance with guidelines issued by the United States Department of Health and Human Services, that he or she meets other exceptional circumstances determined by the SHOP Exchange.

2. With the exception of the qualifying event described in Sections 2.5D.1.f) above, the Special Enrollment Period shall be as follows:

a) For the qualifying event listed in Section 2.5D.1.b) (Qualified Employee or an eligible individual gains, or becomes, a Dependent through marriage, birth, Adoption, placement for Adoption, or grant of court or

testamentary guardianship): The thirty-one (31) day period from the date of the qualifying event.

b) For all other qualifying events listed in Section 2.5D.1: The thirty (30) day period from the date of the qualifying event.

3. Sixty (60) Day Special Enrollment Period. In addition, an eligible individual may enroll as a Subscriber or Dependent upon the occurrence of one of the following qualifying events:

a) The eligible individual loses eligibility for coverage under a Medicaid plan under title XIX of the Social Security Act or a state child health plan under title XXI of the Social Security Act;

b) The eligible individual becomes eligible for assistance, with respect to coverage under a Qualified Health Plan offered through the SHOP Exchange, under such Medicaid plan or a state child health plan (including any waiver or demonstration project conducted under or in relation to such a plan); or

c) An eligible Qualified Employee or Dependent is enrolled in an employer-sponsored health benefit plan that is not qualifying coverage in an eligible employer sponsored plan and is allowed to terminate existing coverage.

4. With the exception of Section 2.5.D.3.c), the Special Enrollment Period for the qualifying events listed in Section 2.5D.3 shall be the sixty (60) day period from the date of the qualifying event. In the event of a qualifying event under Section 2.5.D.3.c), the Special Enrollment Period shall be sixty (60) days prior to the end of coverage under the employer sponsored plan.

E. Effective Dates.

1. The Effective Date for a Qualified Employee or eligible individual who enrolls during an Annual Open Enrollment Period shall be the first day of the new Benefit Period, unless otherwise provided by the SHOP Exchange.

2. The Effective Date for a newly eligible Qualified Employee and any Dependent who timely enrolls as provided in Section 2.5B shall be as stated in the Eligibility Schedule.

3. The Effective Date for a Dependent Child who timely enrolls during a Special Enrollment Period is the Dependent Child's First Eligibility Date:

a) First Eligibility Date means:

(1) For a newborn Dependent Child, the child's date of birth;

(2) For a non-newborn Dependent Child who is a stepchild, the date the stepchild became a Dependent of the Subscriber;

(3) For a newly adopted Dependent Child, the earlier of;

(a) A judicial decree of Adoption; or

(b) Placement of the child in the Subscriber's home as the legally recognized proposed adoptive parent;

(4) For a Dependent Child for whom guardianship of at least twelve (12) months' duration has been granted by court or testamentary appointment, the date of the appointment;

(5) For all other Dependent Children, the first day of the month following the receipt of enrollment by the SHOP Exchange.

b) The Dependent Child will be covered automatically, but only for the first thirty-one (31) days following the child's First Eligibility Date. The Subscriber must enroll such a Dependent Child within thirty-one (31) days of the child's First Eligibility Date when an additional premium is due for the enrollment of the Dependent Child. Otherwise, the Dependent Child will not be covered and cannot be enrolled until the next Annual Open Enrollment Period. (An additional premium will be due unless there are three (3) or more Dependent Children under the age of twenty-one (21) already enrolled by the Subscriber).

4. The Effective Date for a Spouse who becomes a new Dependent and who timely enrolls during a Special Enrollment Period shall be the first day of the month following the receipt of enrollment by the SHOP Exchange.

5. The Effective Date for an eligible Qualified Employee or Dependent who loses other Minimum Essential Coverage who timely enrolls during a Special Enrollment Period shall be the first day of the month following the receipt of enrollment by the SHOP Exchange.

6. The Effective Date for a Qualified Employee or Dependent who timely enrolls due to a qualifying event stated in Section 2.5D.1.c) (enrollment or non-enrollment was unintentional, inadvertent, or erroneous and is the result of an error by the SHOP Exchange or the United States Department of Health and Human Services), Section 2.5D.1.d) (a Qualified Health Plan substantially violated a material provision of its contract), or Section 2.5D.1.g) (other exceptional circumstances as determined by the SHOP Exchange), the Effective Date shall be the appropriate date set by the SHOP Exchange according to guidance issued by the United States Department of Health and Human Services. Such Effective Date shall be either:

a) The date of the event that triggered the Special Enrollment Period under these circumstances; or

b) The date established under Section 2.5E.7 below.

7. In all other cases, the Effective Date for a Qualified Employee or Dependent who timely enrolls during a Special Enrollment Period will be:

a) For enrollment received by the SHOP Exchange between the first and the fifteenth day of the month, the first day of the following month; and

b) For enrollment received by the SHOP Exchange between the sixteenth and the last day of the month, the first day of the second following month.

8. Premium changes resulting from the enrollment of a Subscriber or a Dependent during a Special Enrollment Period will be effective as of the Effective Date of the Subscriber's or the Dependent's enrollment.

2.6 Child Support Orders (MCSO or QMSO).

A. Eligibility and Termination.

1. Upon receipt of an MCSO or QMSO, CareFirst will accept enrollment of a Dependent Child that is the subject of an MCSO or QMSO and the Qualified Employee parent of such child, without regard to enrollment period restrictions, within the time period prescribed by law. Coverage will be effective as of the effective date of the order, and the premium will be adjusted as needed. If the Subscriber does not enroll the child then CareFirst will accept enrollment from the non-Subscriber custodial parent; or, the appropriate child support enforcement agency of any state or the District of Columbia. If the Subscriber is subject to a Waiting Period, the child will not be enrolled until the end of the waiting period.

2. Enrollment for such a child will not be denied because the child:

   a) Was born out of wedlock;

   b) Is not claimed as a dependent on the Subscriber's federal tax return;

   c) Does not reside with the Subscriber; or

   d) Is covered under any Medical Assistance or Medicaid program.

3. Coverage required by an MCSO or QMSO will be effective as of the date of the order.

4. Termination. Unless coverage is terminated for non-payment of the premium, a covered child subject to an MCSO or QMSO may not be terminated unless written evidence is provided to CareFirst stating:

   a) The MCSO or QMSO is no longer in effect;

   b) The child has been or will be enrolled under other comparable health insurance coverage that will take effect not later than the effective date of the termination of coverage;

   c) The Group has eliminated family members' coverage for all its employees; or

   d) The employer no longer employs the insuring parent, except if the parent elects to exercise the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), coverage shall be provided for the child consistent with the Group's plan for postemployment health insurance coverage for Dependents.

B. Administration. When the child subject to an MCSO or QMSO does not reside with the Subscriber, CareFirst will:

1. Send to the non-insuring custodial parent the identification cards, claim forms, the applicable Evidence of Coverage, and any information needed to obtain benefits;

2. Allow the non-insuring custodial parent or a provider of a Covered Service to submit a claim without the approval of the Subscriber; and

3. Provide benefits directly to:

   a) The non-insuring parent;

   b) The provider of the Covered Services, Covered Dental Services or

Covered Vision Services; or

c) The appropriate child support enforcement agency of any state or the District of Columbia.

2.7 Clerical or Administrative Error. If an individual is ineligible for coverage, the individual cannot become eligible just because CareFirst, the Group or the SHOP Exchange made a clerical or administrative error in recording or reporting information. Likewise, if a Member is eligible for coverage, the Member will not lose coverage because CareFirst, the Group or the SHOP Exchange made an administrative or clerical error in recording or reporting information.

2.8 Cooperation and Submission of Information. CareFirst may require verification from the Group and/or Subscriber pertaining to the eligibility of a Subscriber or Dependent enrolled hereunder. The Group and/or Subscriber agree to cooperate with and assist CareFirst and the SHOP Exchange, including providing CareFirst and the SHOP Exchange with reasonable access to Group records upon request. At any time coverage under this Evidence of Coverage is in effect, CareFirst reserves the right to request documentation substantiating eligibility as described in this Evidence of Coverage and to provide any information it receives regarding a Member's eligibility to the Group or the SHOP Exchange.

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

SECTION 3
TERMINATION OF COVERAGE

3.1 Termination of Enrollment by the Subscriber.

A. The Subscriber may terminate his or her enrollment either during the Annual Open Enrollment Period; the Subscriber loses eligibility; or under circumstances permitted by the Group, the SHOP Exchange, or applicable federal, state, or local law.

B. A Subscriber may terminate the enrollment of a Dependent only in the manner permitted by the SHOP Exchange by notifying the Group or the SHOP Exchange.

C. The date of the termination will be:

1. If the Subscriber terminates enrollment during an Annual Open Enrollment Period, on the last day of the Benefit Period.

2. In all other cases:

a) On the date stated by the Subscriber, if the Subscriber has given reasonable notice. For purposes of this provision, reasonable notice is defined as fourteen (14) days from the requested date of termination.

b) Fourteen (14) days after the date the Subscriber requested termination, if the Subscriber does not provide reasonable notice.

c) If the Subscriber and Dependents give notice of termination of enrollment in order to enroll in another Qualified Health Plan, the day before the date of coverage under the new Qualified Health Plan.

d) If the Subscriber and Dependents are newly eligible for Medicaid, the federal child health insurance plan (CHIP) or a State-funded low-income basic health plan (known as a BHP), the day before coverage under one of these programs begins.

3.2 Termination of Individual Enrollment by the CareFirst or the SHOP Exchange. CareFirst or the SHOP Exchange may terminate the coverage of a Subscriber and/or a Dependent under the following circumstances by providing the Subscriber at least thirty (30) days' notice prior to the last day of coverage:

A. Termination of Individual Enrollment for Ineligibility:

1. The Subscriber is no longer eligible for coverage for any reason. In this circumstance, the enrollment of the Subscriber and any Dependents will be terminated.

2. A Dependent is no longer eligible for coverage as a Dependent due to a change in the Dependent's age, status or relationship to the Subscriber, or no longer meets the eligibility requirements established by the Group.

3. The date of termination is stated in the Eligibility Schedule.

4. The Subscriber is responsible for notifying the SHOP Exchange of any changes in the status of a Dependent as an eligible individual; or his or her eligibility for coverage, except when the Dependent Child reaches the Limiting Age. These changes include a divorce and the marriage of a Dependent Child. If the Subscriber knows of a Dependent's ineligibility for coverage and intentionally fails to notify the SHOP Exchange of these types of changes, CareFirst has the

right to seek Rescission of the coverage of the Dependent under Section 3.3 as of the initial date of the Dependent's ineligibility and recover the full value of the services and benefits provided during the period of Dependent's ineligibility. CareFirst can recover these amounts from the Subscriber and/or from the Dependent, less the premium paid during the period of ineligibility, at the option of CareFirst.

B. Termination of Group Contract due to the Decertification of the Evidence of Coverage as a Qualified Health Plan. If this Evidence of Coverage is Decertified as a Qualified Health Plan, the date of termination shall be the date established by the SHOP Exchange after written notice has been provided to the Subscriber and the Subscriber has been afforded an opportunity to enroll in other coverage.

C. Accommodation for Persons with Disabilities. Notwithstanding the termination provisions above, CareFirst, when required by the SHOP Exchange, shall make reasonable accommodation of these provisions for all individuals with disabilities (as defined by the Americans with Disabilities Act) before terminating the coverage of such individuals.

3.3 Rescission of Individual Enrollment for Fraud or Misrepresentation. Coverage of a Member may be Rescinded if:

A. The Member has performed an act, practice, or omission that constitutes fraud;

B. The Member has made an intentional misrepresentation of material fact; or

C. An act, practice or omission that constitutes fraud includes, but is not limited to, fraudulent use of CareFirst's identification card by the Member, the alteration or sale of prescriptions by the Member, or an attempt by a Subscriber to enroll non-eligible persons.

CareFirst will provide thirty (30) days advance written notice of any Rescission. CareFirst shall have the burden of persuasion that its Rescission complies with applicable local law. The Rescission shall either (i) void the enrollment of the Member as of the Member's Effective Date (for fraudulent acts, practices, or omissions that occur at the time of enrollment); or (ii) in all other cases, void the enrollment of the Member as of the first date the Member performed an act, practice or omission which constituted fraud or made an intentional misrepresentation of material fact. The Subscriber will be responsible for payment of any voided benefits paid by CareFirst, net of applicable premiums paid.

3.4 Death of Subscriber. In the event of the Subscriber's death, coverage of any Dependents may continue under the Subscriber's enrollment as stated in this Evidence of Coverage. The date of termination of the Subscriber's enrollment and, if applicable, the enrollment of any Dependents will be as stated in the Eligibility Schedule.

3.5 Medical Child Support Orders or Qualified Medical Support Orders. Unless coverage is Rescinded or terminated for non-payment of the premium, a child subject to an MCSO/QMSO may not be terminated unless written evidence is provided to CareFirst or the SHOP Exchange that:

A. The MCSO/QMSO is no longer in effect;

B. The child has been or will be enrolled under other comparable health insurance coverage that will take effect not later than the date of the termination of coverage;

C. The Group has eliminated family member coverage for all Members; or

D. The Group no longer employs the Subscriber, except if the Subscriber elects continuation coverage under applicable state or federal law the child will continue in this post-employment coverage.

3.6 Termination of Evidence of Coverage upon Termination of Group Contract. This Evidence of Coverage, and the enrollment of the Member(s), will terminate automatically upon the date of the termination of the Group Contract by the Group, the SHOP Exchange or CareFirst for any reason.

3.7 Effect of Termination. No benefits will be provided for any services received on or after the date on which the Member's coverage terminates. This includes services received for an injury or illness that occurred before the date of termination.

3.8 No Reinstatement. Upon termination, enrollment will not reinstate automatically under any circumstances.

SECTION 4
CONTINUATION OF COVERAGE

4.1 Continuation of Eligibility upon Loss of Group Coverage.

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

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

If an eligible employee leaves his or her job to perform military service, the eligible employee has the right to elect to continue his or her Group coverage including any Dependents for up to twenty-four (24) months while in the military. Even if continuation of coverage was not elected during the eligible employee's military service, the eligible employee has the right to be reinstated in their Group coverage when re-employed, without any Waiting Periods or pre-existing condition exclusion periods except for service connected illnesses or injuries. If an eligible employee has any questions regarding USERRA, the eligible employee should contact the plan administrator. The plan administrator determines eligible employees and provides the information to CareFirst.

4.2. District of Columbia Continuation of Health Coverage (DCCHC). This provision applies to Subscribers enrolled in an employer-maintained health benefit plan for less than twenty (20) employees.

A. The Subscriber and any Dependents have the right to continue coverage under the Group Contract for a period of three (3) months, or for the period of time during which the Subscriber is eligible for premium assistance under the American Recovery and Reinvestment Act of 2009, as amended, unless:

1. The Subscriber's employment was terminated for gross misconduct;

2. The Member is eligible for any extension of coverage required under COBRA; or

3. The Member fails to complete timely election and payment as provided below.

B. Duties of the Group.

1. The Group shall furnish Subscribers whose coverage terminates with written notification of the Subscriber's eligibility to continue coverage under DCCHC. Such notice shall be furnished no later than fifteen (15) days of the date coverage under this Evidence of Coverage would otherwise terminate. Failure by the Group to furnish the required notification shall not extend the right to continue coverage beyond the three-month period, or for the period of time during which the Subscriber is eligible for premium assistance under the American Recovery and Reinvestment Act of 2009, as amended.

2. The Group shall forward to CareFirst the names of Members who apply for DCCHC Continuation of Coverage within fifteen (15) days from the date of application.

C. Duties of the Subscriber.

1. Individuals who elect coverage under this Section shall bear the cost of the continued coverage and such cost shall not exceed one hundred two percent (102%) of the Group's rate.

2. An individual who elects to continue coverage shall tender to the Group the amount described above within forty-five (45) days from the date coverage under this Evidence of Coverage would otherwise terminate.

D. Termination of Continued Coverage. Coverage under this provision shall continue without interruption for the continued eligibility period and shall not terminate unless:

1. The Member establishes residence outside CareFirst Service Area;

2. The Member fails to make timely payment of the required cost of coverage;

3. The Member violates a material condition of this Evidence of Coverage;

4. The Member becomes covered under another group health benefits plan that does not contain any exclusion or limitation with respect to any preexisting condition that affects the Member;

5. The Member becomes entitled to Medicare; or

6. The Group no longer offers group coverage to any employee.

E. The Member shall be entitled to a Conversion Contract in accordance with Section 5 upon termination of his/her continued eligibility period as defined in this Section.

4.3 Right to Continue Coverage Under Only One Provision. If a Member is eligible to continue coverage under the Group Contract under more than one continuation provision as described above, the Member will receive only one such continuation coverage. The Group will select the continuation option the member will receive.

SECTION 5
CONVERSION PRIVILEGE

5.1 Conversion Privilege.

A. Group Conversion

1. A Member who has been covered under the Group Contract for at least three (3) months shall be eligible for a Conversion Contract without evidence of insurability.

2. If a Member is entitled to continue coverage through a Conversion Contract, CareFirst will notify the Member of the conversion option within sixty-one (61) days of the date coverage terminates. CareFirst must receive the Member's application form, including full payment of the applicable premium, within thirty-one (31) days after the date of termination, or within thirty-one (31) days following CareFirst's notice, whichever is later. However, if CareFirst does not notify the Member of this conversion privilege or there is a delay in giving this notice, the time period within which a Member can elect to convert will not extend beyond ninety (90) days following the termination date.

3. Conversion coverage is effective on the day following the date the Group Contract terminated or the Member's coverage under this Evidence of Coverage terminated.

4. Benefits under Conversion Contracts may vary from the benefits under this Evidence of Coverage and CareFirst reserves all rights, subject to applicable requirements of law, to determine the form and terms of the Conversion Contract(s) CareFirst issues.

B. Conversion Privilege Triggers.

1. Subscriber No Longer Eligible for Group Coverage. If the Subscriber's coverage terminates because the Subscriber is no longer an employee or participant of the Group or no longer meets the Group's eligibility requirements for health benefits coverage, the Subscriber may purchase a Conversion Contract to cover himself/herself and his/her covered Dependents.

2. Upon Subscriber's Death. Following the death of a Subscriber, the enrolled Spouse and Dependent Children or, if there is no Spouse, the covered Dependent children of the Subscriber, may purchase a Conversion Contract.

3. Upon Termination of Marriage. If a Spouse's coverage terminates because of legal separation, divorce or because the marriage is legally annulled, the Spouse is entitled to purchase a Conversion Contract.

4. Upon Termination of Coverage of a Child. If coverage of a Dependent Child terminates because the child no longer meets the eligibility requirements (e.g., the child marries, attains the Limiting Age, becomes capable of self-support, etc.) the child is entitled to purchase a Conversion Contract.

5. Upon Termination of the Group Contract by the Group. If coverage terminates because of the termination of the Group Contract by the Group, the Member may purchase a Conversion Contract if the Group has not provided for continued coverage through another health plan or other Group insurance program offered by or through the Group.

6. Upon Expiration of Continued Coverage. A Member may purchase a Conversion Contract upon expiration of continuation of coverage.

C. Exceptions.

1. CareFirst will not issue a Conversion Contract if the Member is enrolled in a health maintenance organization, or is covered or eligible for coverage under another group policy which provides benefits substantially equal to the minimum benefits of the Conversion Contract.

2. CareFirst will not issue a Conversion Contract if:

   a) The person is covered for similar benefits by another hospital, surgical, medical or major medical expense insurance policy, or hospital or medical service subscriber contract, or medical practice, health maintenance organization, or other prepayment plan, or by any other plan or program;

   b) The person is covered for similar benefits under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis, or whether the person is in the military service; or,

   c) Similar benefits are provided for or available to this person, pursuant to or in accordance with the requirements of any state or federal law.

3. CareFirst will not issue a Conversion Contract if benefits provided or available to the person under this section, together with the Conversion Contract, would result in overinsurance according to CareFirst's standards on file with the Virginia Bureau of Insurance.

4. CareFirst will not issue a Conversion Contract to a person eligible for Medicare, or continue coverage under a Conversion Contract beyond the date when the person is eligible for Medicare.

SECTION 6
COORDINATION OF BENEFITS (COB); SUBROGATION

6.1 Coordination of Benefits (COB).

A. Applicability.

1. This Coordination of Benefits (COB) provision applies to this CareFirst Plan when a Member has health care coverage under more than one Plan.

2. If this COB provision applies, the Order of Benefit Determination Rules should be reviewed first. Those rules determine whether the benefits of this CareFirst Plan are determined before or after those of another Plan. The benefits of this CareFirst Plan:

a) Shall not be coordinated when, under the order of determination rules, this CareFirst Plan determines its benefits before another Plan;

b) May be coordinated when, under the order of determination rules, another Plan determines its benefits first. The coordination is explained in Section 6.1D.2.

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

Allowable Expenses means any health care expense, including deductibles, coinsurance or copayments that are covered in whole or in part by any of the Plans covering the Member. This means any expense or portion of an expense not covered by any of the Plans is not an Allowable Expense. If this CareFirst Plan is advised by a Member that all Plans covering the Member are high-deductible health plans and the Member intends to contribute to a health savings account, the primary Plan's deductible is not an Allowable Expense, except for any health care expense incurred that may not be subject to the deductible, as stated in Section 223(c)(2)(C) of the Internal Revenue Code of 1986.

CareFirst Plan means this Evidence of Coverage.

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

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

The term Plan does not include:

1. An individually underwritten and issued, guaranteed renewable, specified disease policy;

2. An intensive care policy, which does not provide benefits on an expense incurred basis;

3. Coverage regulated by a motor vehicle reparation law;

4. The first one-hundred dollars ($100) per day of a hospital indemnity contract; or

5. An elementary and/or secondary school insurance program sponsored by a school or school system.

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

1. When this CareFirst Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

2. When this CareFirst Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be coordinated because of the other Plan's benefits.

3. When there are more than two Plans covering the Member, this CareFirst Plan may be a Primary Plan as to one of the other Plans, and may be a Secondary Plan as to a different Plan or Plans.

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

C. Order of Benefit Determination Rules.

1. General. When there is a basis for a claim under this CareFirst Plan and another Plan, this CareFirst Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless;

   a) The other Plan has rules coordinating benefits with those of this CareFirst Plan; and

   b) Both those rules and this CareFirst Plan's rules require this CareFirst Plan's benefits be determined before those of the other Plan.

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

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

      (1) Secondary to the Plan covering the person as a dependent, and

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

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

b) Dependent child covered by more than one Plan. Unless there is a court decree stating otherwise, when this CareFirst Plan and another Plan cover the same child as a dependent, the order of benefits shall be determined as follows:

(1) For a dependent child whose parents are married or are living together:

(a) The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in the year; but

(b) If both parents have the same birthday, the benefits of the Plan that covered one parent longer are determined before those of the Plan that covered the other parent for a shorter period of time.

(2) For a dependent child whose parents are separated, divorced, or are not living together:

(a) If the specific terms of a court decree state one of the parents is responsible for the health care expenses or health care coverage of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but the parent's Spouse does, that parent's Spouse's plan is the primary plan. This paragraph does not apply with respect to any claim for services rendered before the entity has actual knowledge of the terms of the court decree.

The rule described in (1) above also shall apply if: i) a court decree states both parents are responsible for the dependent child's health care expenses or health care coverage, or ii) a court decree states the parents have joint custody without specifying one parent has responsibility for the health care expenses or coverage of the dependent child.

(b) If there is no court decree setting out the responsibility for the child's health care expenses or health care coverage, the order of benefits for the dependent child are as follows:

i) The Plan of the parent with custody of the child;

ii) The Plan of the Spouse of the parent with the custody of the child;

iii) The Plan of the parent not having custody of the child; and then

iv) The Plan of the Spouse of the parent who does not have custody of the child.

(3) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under the rules stated in (1) and (2) of this paragraph as if those individuals were parents of the child.

c) Active/inactive employee. The benefit of a Plan which covers a person as an employee who is neither laid off nor retired is determined before those of a Plan that covers that person as a laid off or retired employee. The same would hold true if a person is a dependent of a person covered as an employee who is neither laid off nor retired or a person covered as a laid off or retired employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

d) Continuation coverage. If a person whose coverage is provided under the right of continuation pursuant to federal, state or local law also is covered under another Plan, the following shall be the order of benefits determination:

(1) First, the benefits of a Plan covering the person as an employee, retiree, member or subscriber (or as that person's dependent);

(2) Second, the benefits under the continuation coverage.

If the other Plan does not have the rule described above, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

e) Longer/shorter length of coverage. If none of the above rules determines the order of benefits, the benefits of the Plan that covered the person longer are determined before those of the Plan that covered that person for the shorter term.

D. Effect on the Benefits of this CareFirst Plan.

1. When this Section Applies. This section applies when, in accordance with the prior section, order of benefits determination rules, this CareFirst Plan is a Secondary Plan as to one or more other Plans. In such an event, the benefits of this CareFirst Plan may be coordinated under this section. Any additional other Plan or Plans are referred to as "the other Plans" immediately below.

2. Coordination in this CareFirst Plan's Benefits. When this CareFirst Plan is the Secondary Plan, the benefits under this CareFirst Plan *may* be coordinated so that the total benefits would be payable or provided by all the other Plans do not exceed one hundred percent (100%) of the total Allowable Expenses. If the benefits of this CareFirst Plan are coordinated, each benefit is coordinated in proportion. It is then charged against any applicable benefit limit of this CareFirst Plan.

E. Right to Receive and Release Needed Information. Certain facts are needed to apply these COB rules. CareFirst has the right to decide which facts it needs. It may get the needed facts from or give them to any other organization or person for purposes of treatment, payment, and health care operations. CareFirst need not tell, or get the consent of, any person to do this. Each person claiming benefits under this CareFirst Plan must give this CareFirst Plan any facts it needs to pay the claim.

F. Facility of Payment. A payment made under another Plan may include an amount that should have been paid under this CareFirst Plan. If it does, this CareFirst Plan may pay the amount to the organization that made that payment. The amount will then be treated as though it were a benefit paid under this CareFirst Plan. This CareFirst Plan will not have to pay the amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

G. Right of Recovery. If the amount of the payments made by this CareFirst is more than it should have paid under this COB provision, it may recover the excess from one or more of:

1. The persons it has paid or for whom it has paid;

2. Insurance companies; or

3. Other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

6.2 Medicare Eligibility. This provision applies to Members who are entitled to Part A and/or Part B of Medicare. A Member will not be terminated as a result of reaching the age of sixty-five (65) or becoming eligible for Medicare. Benefits not covered by Medicare will be provided as described in the Evidence of Coverage. Benefits covered by Medicare are subject to the provisions in this section.

A. Coverage Secondary to Medicare. Except where prohibited by law, the benefits under this CareFirst Plan are secondary to Medicare.

B. Medicare as Primary.

1. When benefits for Covered Services, Covered Dental Services or Covered Vision Services are paid by Medicare as primary, this CareFirst Plan will not duplicate those payments. CareFirst will coordinate and pay benefits based on Medicare's payment (or the payment Medicare would have paid). When CareFirst coordinates the benefits with Medicare, CareFirst's payments will be based on the Medicare allowance (if the provider is a participating provider in Medicare) or the Medicare maximum limiting charge (if the provider is not a participating provider in Medicare), less any claim reduction or denial due to a Member's failure to comply with Medicare's administrative requirements. CareFirst's right to coordinate is not contingent on any payment actually being made on the claim by Medicare. Members enrolled in Medicare agree to, and shall, complete and submit to Medicare, CareFirst, and/or any health care providers all claims, consents, releases, assignments and other documents required to obtain or assure such claim payment by Medicare.

2. If a Medicare-eligible Member has not enrolled in Medicare Part A and/or Part B, CareFirst will not "carve-out," coordinate, or reject a claim based on the amount Medicare would have paid had the Member actually applied for, claimed, or received Medicare benefits.

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

A. Under any federal, state, county or municipal workers' compensation or employer's liability law or other similar program; or

B. From any federal, state, county or municipal or other government agency, including, in the case of service-connected disabilities, the United States Department of Veterans Affairs, to the extent that benefits are payable by the federal, state, county or municipal or other government agency, but excluding Medicare benefits and Medicaid benefits.

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

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

Recovery means to be successful in a lawsuit, to collect or obtain an amount; to obtain a favorable or final judgment; to obtain an amount in any legal manner; an amount finally collected or the amount of judgment as a result of an action brought against a third-party or involving uninsured or underinsured motorist claims. A Recovery does not include payments made to the Member under the Member's personal injury protection policy. CareFirst will not recover medical expenses from a Subscriber unless the Subscriber or Member recovers for medical expenses in a cause of action or settlement.

A. The Member shall notify CareFirst as soon as reasonably possible that a third-party may be liable for the injuries or illnesses for which benefits are being provided or paid.

B. To the extent actual payments made by CareFirst result from the occurrence that gave rise to the cause of action, CareFirst shall be subrogated and succeed to any right of recovery of the Member against any person or organization.

C. The Member shall pay CareFirst the amount recovered by suit, settlement, or otherwise from any third-party's insurer, any uninsured or underinsured motorist coverage, or as permitted by law, to the extent any actual payments made by CareFirst result from the occurrence that gave rise to the cause of action.

D. The Member shall furnish information and assistance, and execute papers that CareFirst may require to facilitate enforcement of these rights. The Member shall not commit any action prejudicing the rights and interests of CareFirst.

E. In a subrogation claim arising out of a claim for personal injury, the amount recovered by CareFirst may be reduced by:

1. Dividing the total amount of the personal injury recovery into the total amount of the attorney's fees incurred by the injured person for services rendered in connection with the injured person's claim; and

2. Multiplying the result by the amount of CareFirst's subrogation claim. This percentage may not exceed one-third (1/3) of CareFirst's subrogation claim.

F. On written request by CareFirst, a Member or Member's attorney who demands a reduction of the subrogation claim shall provide CareFirst with a certification by the Member that states the amount of the attorney's fees incurred.

G. These provisions do not apply to residents of the Commonwealth of Virginia.

SECTION 7
GENERAL PROVISIONS

7.1 Entire Certificate; Changes. The entire Evidence of Coverage includes: (a) this Evidence of Coverage; (b) [Benefit Determinations and Appeals]; (c) the Description of Covered Services; (d) Schedule of Benefits; (e) Eligibility Schedule; and (f) any additional duly authorized notices, amendments and riders.

No amendment or modification of any term or provision of this Evidence of Coverage is effective unless authorized in writing by an executive officer of CareFirst. Any duly authorized notice, amendment or rider will be issued by CareFirst to be attached to the Evidence of Coverage. No agent has authority to change this agreement or to waive any of its provisions. Any waiver of an Evidence of Coverage term or provision shall only be given effect for its stated purpose and shall not constitute or imply any subsequent waiver.

Oral statements cannot be relied upon to modify or otherwise affect the benefits, limitations and/or exclusions of this Evidence of Coverage, or increase or void any coverage or reduce any benefits. Such oral statements cannot be used in the prosecution or defense of a claim.

7.2 Claims and Payment of Claims.

A. Claim Forms. CareFirst does not require a written notice of claims. A claim form can be requested by calling the Member and Provider Service telephone number on the identification card during regular business hours. CareFirst shall provide claim forms for filing proof of loss to each claimant or to the Group for delivery to the claimant. If CareFirst does not provide the claim forms within fifteen (15) days after notice of claim is received, the claimant is deemed to have complied with the requirements of the policy as to proof of loss if the claimant submits, within the time fixed in the policy for filing proof of loss, written proof of the occurrence, character, and extent of the loss for which the claim is made.

When a child subject to a Medical Child Support Order or a Qualified Medical Support Order does not reside with the Subscriber, CareFirst will:

1. Send the non-insuring, custodial parent identification cards, claims forms, the applicable certificate of coverage or member contract, and any information needed to obtain benefits;

2. Allow the non-insuring, custodial parent or a provider of a Covered Service to submit a claim without the approval of the Subscriber; and

3. Provide benefits directly to:

   a) The non-insuring, custodial parent;

   b) The provider of the Covered Services, Covered Dental Services, or Covered Vision Services; or

   c) The appropriate child support enforcement agency of any state or the District of Columbia.

B. Proof of Loss.

For Covered Services provided by Preferred Providers, Preferred and Participating Dentists, Contracting Vision Providers, and Contracting Pharmacies, Members are not required to submit claims in order to obtain benefits.

For Covered Services provided by Non-Preferred Providers, Non-Participating Dentists, Non-Contracting Vision Providers, and Non-Contracting Pharmacies, Members must furnish written proof of loss, or have the provider submit proof of loss, to CareFirst within one-hundred and eighty (180) days after the date of the loss. The Member is also responsible for providing information requested by CareFirst, including, but not limited to, medical records.

Failure to furnish proof within the time required shall not invalidate or reduce any claim if it was not reasonably possible to give proof within the required time, provided proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one (1) year from the time proof is otherwise required.

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

C. Time of Payment of Claims. Benefits payable will be paid immediately after receipt of written proof of loss.

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

E. Payment of Claims. Payments for Covered Services will be made by CareFirst directly to Contracting Vision Providers, Participating and Preferred Dentists and Preferred Providers. Direct payments will also be made by CareFirst to providers from the United States Department of Defense and the United States Department of Veteran Affairs. If a Member receives Covered Services from Non-Contracting Vision or Non-Preferred or Non-Participating Providers, CareFirst reserves the right to pay either the Member or the provider. If the Member has paid the health care provider for services rendered, benefits will be payable to the Member. The payment will, in either case, be full and complete satisfaction of CareFirst's obligation, unless an appeal or grievance has been filed by, or on behalf of, the Member.

7.3 No Assignment. A Member cannot assign any benefits or payments due under this Evidence of Coverage to any person, corporation or other organization, except as specifically provided by this Evidence of Coverage or required by applicable law.

7.4 Legal Actions. A Member cannot bring any lawsuit against CareFirst to recover under this Evidence of Coverage before the expiration of sixty (60) days after written proof of loss has been furnished, and not after three (3) years from the date written proof of loss is required to be submitted to CareFirst.

7.5 Events Outside of CareFirst's Control. If CareFirst, for any reason beyond the control of CareFirst, is unable to provide the coverage promised, CareFirst is liable for reimbursement of the expenses necessarily incurred by any Member in procuring the services through other providers, to the extent prescribed by law.

7.6 Physical Examinations and Autopsy. CareFirst, at its own expense, has the right and opportunity to examine the Member when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

7.7 Identification Card. Any cards issued to Members are for identification only.

A. Possession of an identification card confers no right to benefits.

B. To be entitled to such benefits, the holder of the card must, in fact, be a Member on whose behalf all applicable premiums have actually been paid.

C. Any person receiving benefits to which he or she is not then entitled will be liable for the actual cost of such benefits.

7.8 Member Medical Records. It may be necessary to obtain Member medical records and information from hospitals, Skilled Nursing Facilities, physicians or other practitioners who treat the Member. When a Member becomes covered, the Member (and, if the Member is legally incapable of giving such consent, the representative of such Member) automatically gives CareFirst permission to obtain and use such records and information, including medical records and information requested to assist CareFirst in determining benefits and eligibility of Members.

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

7.10 Relationship of CareFirst to Health Care Providers. Health care providers, including Preferred Providers, Preferred or Participating Dentists, Contracting Vision Providers, and Contracting Pharmacy Providers, are independent contractors or organizations and are related to CareFirst by contract only. Preferred Providers, Preferred or Participating Dentists, Contracting Vision Providers, and Contracting Pharmacy Providers are not employees or agents of CareFirst and are not authorized to act on behalf of or obligate CareFirst with regard to interpretation of the terms of the Evidence of Coverage, including eligibility of Members for coverage or entitlement to benefits. Preferred Providers, Preferred or Participating Dentists, Contracting Vision Providers, and Contracting Pharmacy Providers maintain a provider-patient relationship with the Member and are solely responsible for the professional services they provide. CareFirst is not responsible for any acts or omissions, including those involving malpractice or wrongful death of Preferred Providers, Preferred or Participating Dentists, Contracting Vision Providers, Contracting Pharmacy Providers, or any other individual, facility or institution which provides services to Members or any employee, agent or representative of such providers.

7.11 Provider and Services Information. Listings of current Preferred Providers, Preferred or Participating Dentists, Contracting Vision Providers, and Contracting Pharmacy Providers will be made available to Members at the time of enrollment. Updated listings are available to Members upon request. The listing of Preferred Providers, Preferred Dentists and Contracting Vision Providers is updated every fifteen (15) days on the CareFirst website (www.carefirst.com).

7.12 Administration of Evidence of Coverage. CareFirst may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Evidence of Coverage.

7.13 CareFirst's Relationship to the Group. The Group is not an agent or representative and is not liable for any acts or omissions by CareFirst or any health care provider. CareFirst is not an agent or representative of the Group and is not liable for any act or omission of the Group.

7.14 Delivery of Evidence of Coverage. Unless CareFirst makes delivery directly to the Member, CareFirst will provide to the Group, for delivery to each Subscriber, a statement that summarizes the essential features of the coverage and states to whom benefits under the Evidence of Coverage are payable. Only one (1) statement will be issued for each family unit, except in the instance of an eligible child who is covered due to an MCSO/QMSO. In this instance, an additional Evidence of Coverage will be delivered to the custodial parent upon request.

7.15 Evidence of Coverage Binding on Members. The Evidence of Coverage can be amended, modified or terminated in accordance with any provision of the Evidence of Coverage or by mutual agreement between CareFirst and the Group without the consent or concurrence of Members. By electing coverage under this Evidence of Coverage, or accepting benefits under this Evidence of Coverage, Members are subject to all terms, conditions, and provisions of the Group Contract and Evidence of Coverage.

7.16 Payment of Contributions. The Group Contract is issued to the Group on a contributory basis in accordance with the Group's policies. The Group has agreed to collect from Members any contributory portion of the premium and pay to the SHOP Exchange the premium as specified in the Group Contract for all Members.

7.17 Rights under Federal Laws. The Group may be subject to federal law (including the Employee Retirement Income Security Act of 1974, as amended (ERISA), the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and/or the Affordable Care Act) that relates to the health benefits provided under this Group Contract. For the purposes of ERISA and/or COBRA, the Group is the "plan administrator." As the plan administrator, it is the Group's responsibility to provide Members with certain information, including access to and copies of plan documents describing Member's benefits and rights to coverage under the Group health plan. Such rights include the right to continue coverage upon the occurrence of certain "Qualifying Events."

In any event, the Member should check with the Group to determine the Member's rights under ERISA, COBRA, HIPAA and/or the Affordable Care Act, as applicable.

7.18 Representations and not Warranties. All statements made by the Subscriber shall be deemed to be representations and not warranties. No statement made for the purpose of obtaining coverage shall void such coverage or reduce benefits unless contained in a written instrument signed by the Subscriber, a copy of which has been furnished to CareFirst.

7.19 Rules for Determining Dates and Times. The following rules will be used when determining dates and times:

A. All dates and times of day will be based on the dates and times applicable to the Washington, DC area, i.e., Eastern Standard Time or Eastern Daylight Savings Time, as applicable.

B. When reference is made to coverage being effective on a particular date, this means 12:01 a.m. on that date.

C. When reference is made to termination being effective on a particular date, this means 12:00 midnight on that date.

D. "Days" mean calendar days, including weekends, holidays, etc., unless otherwise noted.

E. "Year" refers to Calendar Year, unless a different benefit year basis is specifically stated.

7.20 Notices.

A. To the Member. Notice to Members will be sent via electronic mail, if the Member has consented to receive such notices via electronic mail, or by first class mail to the most recent address or electronic address for the Member in CareFirst's files. It is the Subscriber's responsibility to notify the Group, and the Group's responsibility to notify CareFirst, of an address change. The notice will be effective on the date mailed, whether or not the Member in fact receives the notice or there is a delay in receiving the notice. The notice will be effective on the date mailed, whether or not the Member in fact receives the notice or there is a delay in receiving the notice.

B. To CareFirst. When notice is sent to CareFirst, it must be sent by first class mail to:

Group Hospitalization and Medical Services, Inc.
[840 First Street, NE]
[Washington, DC 20065]

1. Notice will be effective on the date of receipt by CareFirst, unless the notice is sent by registered mail, in which case the notice is effective on the date of mailing, as certified by the Postal Service.

2. CareFirst may change the address at which notice is to be given by giving written notice thereof to the Subscriber.

7.21 Amendment Procedure. Amendments must be consistent with state law.

CareFirst will give notice of any amendment at least sixty (60) days before the effective date of the amendment, unless the modification is mandated to conform with any applicable changes to state or federal law. Regardless of when the amendment is received, this Evidence of Coverage is considered to be automatically amended on the date specified in the contract amendment or the notice of the amendment to the Group (if not stated in the contract amendment), unless otherwise mandated to conform with any applicable changes to state or federal law.

No agent or other person, except an officer of CareFirst, has the authority to waive any conditions or restrictions of the Evidence of Coverage or to bind CareFirst by making any promise or representation or by giving or receiving any information. No change in the Evidence of Coverage will be binding on CareFirst, unless evidenced by an amendment signed by an authorized representative of CareFirst.

7.22 Regulation of CareFirst. CareFirst is subject to regulation in the District of Columbia by the Department of Insurance, Securities and Banking pursuant to Title 31 of the District of Columbia Code and the District of Columbia Department of Health pursuant to Reorganization Plan No. 4 of 1996, as amended.

7.23 Conformity to Law. Any provision in this Evidence of Coverage that is in conflict with the requirements of any state or federal law that applies to this Evidence of Coverage is automatically changed to satisfy the minimum requirements of such law.

[7.24 Selection of a Primary Care Physician. Consultation and visits with a Primary Care Physician are required to be able to satisfy the requirements of the Wellness Credit Section as stated in the Description of Covered Services.

A. For a Member in the CareFirst Service Area. A Member may identify any Primary Care Physician from CareFirst's current list of Preferred Providers. If the Primary Care Physician is not available, CareFirst will assist the Member in identifying another selection.

B. For a Member outside the CareFirst Service Area. The Member must consult and visit a Primary Care Physician who is a BlueCard PPO Network Provider as defined in the [Inter-Plan Arrangements Disclosure Amendment].]