Montgomery County Public Schools

Vision Care Option
Actives

Group Hospitalization and Medical Services, Inc.

doing business as

CareFirst BlueCross BlueShield

840 First Street, NE
Washington, DC 20065
202-479-8000

An independent licensee of the Blue Cross and Blue Shield Association

EVIDENCE OF COVERAGE

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

CareFirst provides administrative claims payment services only and does not assume any financial risk or obligation with respect to those claims.

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

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

CareFirst has provided this Evidence of Coverage, including any amendments or riders applicable thereto, to the Group in electronic format. Any errors, changes and/or alterations to the electronic data, resulting from the data transfer or caused by any person shall not be binding on CareFirst. Such errors, changes and/or alterations do not create any right to additional coverage or benefits under the Group's health benefit plan as described in the health benefit plan documents provided to the Group in hard copy format.

Group Name: Montgomery County Public Schools

Account Number(s): 66827

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DEFINITIONS

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

Allowed Benefit means:

1. For a Participating Provider, the Allowed Benefit for a Covered Service is the lesser of:

    a. The actual charge; or

    b. The amount CareFirst allows for the service in effect on the date that the service is rendered.

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

2. For a Non-Participating Provider, the Allowed Benefit for a Covered Service will be determined in the same manner as the Allowed Benefit payable to a Participating Provider. The benefit is payable to the Subscriber, or to the Non-Participating Provider, at the discretion of CareFirst. The Member is responsible for any applicable Member payment amounts, as stated in the Schedule of Benefits, and for the difference between the Allowed Benefit and the Non-Participating Provider's actual charge. It is the Member's responsibility to apply any CareFirst payments to the Non-Participating Provider's charges.

Benefit Period means the period of time during which Covered Services are eligible for payment. The Benefit Period is:

Eighteen (18) months from the first Covered Service. Benefits are limited to once per Benefit Period.

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

Claims Administrator means CareFirst.

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.

Copayment (Copay) means a fixed dollar amount that a Member must pay for certain Covered Services. When a Member receives multiple services on the same day by the same Health Care Provider, the Member will only be responsible for one (1) Copay.

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

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

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

Dependent means a Member, other than the Subscriber, meeting the eligibility requirements established by the Group, who is covered under this Evidence of Coverage.

Dependent includes a child who has not attained the Limiting Age stated in the Eligibility Schedule irrespective of the child's:

1. Financial dependency on an individual covered under this Evidence of Coverage;

2. Marital status;

3. Residency with an individual covered under this Evidence of Coverage;

4. Student status;

5. Employment; or

6. Satisfaction of any combination of the above factors.

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

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

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

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

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

3. The Technology must improve the net health outcome;

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

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

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

FDA means the U.S. Food and Drug Administration.

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

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

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

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

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

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

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

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

3. Not primarily for the convenience of a patient or Health Care Provider; and

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

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

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

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

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

Paid Claims means the amount paid by CareFirst for Covered Services. Other payments relating to fees and programs applicable to CareFirst’s role as Claims Administrator may also be included in Paid Claims.

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

Plan means that portion of the Welfare Benefit Plan established by the Group that provides for health care benefits for which CareFirst is the Claims Administrator under this Group Contract.

Rescission means a 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. A cancellation or discontinuance of coverage is not a Rescission if:

1. The cancellation or discontinuance of coverage has only a prospective effect; or

2. The 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.

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

Type of Coverage means either Individual coverage, which covers the Subscriber only, or Family Coverage, under which a Subscriber may also enroll his or her Dependents. Some Group Contracts include additional categories of coverage, such as Individual and Adult and Individual and Child. The Types of Coverage available under this Evidence of Coverage are Individual, Individual and Child, Individual and Adult, Family.

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

Waiting Period means the period of time that must pass before an employee or dependent is eligible to enroll under the terms of the Group Health Plan. A Waiting Period determined by the Group may not exceed the limits required by applicable federal law and regulation.

ELIGIBILITY AND ENROLLMENT

A. **Requirements for Coverage**

The Group has the sole and complete authority to make determinations regarding eligibility and enrollment for membership in the Plan.

An eligible participant of the Group, and his or her Dependent(s) meeting the eligibility requirements established by the Group, may be covered under the Evidence of Coverage (see Eligibility Schedule) when all of the following conditions are met:

1. The individual elects coverage;

2. The Group accepts the individual's election and notifies CareFirst; and

3. Payments are made on behalf of the Member by the Group.

B. **Enrollment Opportunities and Effective Dates**

Eligible individuals may elect coverage as Subscribers or Dependents, as applicable, only during the following times and under the following conditions. If an individual meets these conditions, his or her enrollment will be treated as timely enrollment. Enrollment at other times will be treated as special enrollment and will be subject to the conditions and limitations stated in Special Enrollment Periods. Disenrollment is not allowed during a contract year except as stated in section B.1., and as stated in the Termination of Coverage section of the Evidence of Coverage.

1. **Open Enrollment Period**

Open Enrollment changes will be effective on the Open Enrollment effective date stated in the Eligibility Schedule.

a. During the Open Enrollment period, all eligible persons may elect, change, or voluntarily disenroll from coverage, or transfer coverage between CareFirst and all other alternate health care plans available through the Group.

b. In addition, Subscribers already enrolled in CareFirst may change their Type of Coverage (e.g., from Individual to Family Coverage) and/or add eligible Dependents not previously enrolled under their coverage.

2. **Newly Eligible Subscriber**

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

3. **Special Enrollment Periods**

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

These special enrollment periods are not the same as Medicare special enrollment periods.

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

If retirees are eligible for coverage under this Evidence of Coverage, references to an employee shall be construed to include a retiree, except for references made within the "Special enrollment for certain individuals who lose coverage" subsection below, as special enrollment for certain enrollment who lose coverage is not applicable to retirees.

a. Special enrollment for certain individuals who lose coverage:

1) CareFirst will permit current employees and dependents to enroll for coverage without regard to the dates on which an individual would otherwise be able to enroll under this Evidence of Coverage.

2) Individuals eligible for special enrollment.

a) When employee loses coverage. A current employee and any dependents (including the employee's spouse) each are eligible for special enrollment in any benefit package offered by the Group (subject to Group eligibility rules conditioning dependent enrollment on enrollment of the employee) if:

(1) The employee and the dependents are otherwise eligible to enroll;

(2) When coverage was previously offered, the employee had coverage under any group health plan or health insurance coverage; and

(3) The employee satisfies the conditions of paragraph B.3.a.3)a), b), or c) of this section, and, if applicable, paragraph B.3.a.3)d) of this section.

b) When dependent loses coverage. A dependent of a current employee (including the employee's spouse) and the employee each are eligible for special enrollment in any benefit package offered by the Group (subject to Group eligibility rules conditioning dependent enrollment on enrollment of the employee) if:

(1) The dependent and the employee are otherwise eligible to enroll;

(2) When coverage was previously offered, the dependent had coverage under any group health plan or health insurance coverage; and

(3) The dependent satisfies the conditions of paragraph B.3.a.3)a), b), or c) of this section, and, if applicable, paragraph B.3.a.3)d) of this section.

(4) However, CareFirst is not required to enroll any other dependent unless the dependent satisfies the criteria of this paragraph B.3.a.2)b), or the employee satisfies the criteria of paragraph B.3.a.2)a) of this section.

3) Conditions for special enrollment.

a) Loss of eligibility for coverage. In the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions of this paragraph B.3.a.3)a) are satisfied at the time the coverage is terminated as a result of loss of eligibility (regardless of whether the individual is eligible for or elects COBRA continuation coverage). Loss of eligibility under this paragraph does not include a loss due to the failure of the employee or dependent to pay premiums on a timely basis or

termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact). Loss of eligibility for coverage under this paragraph includes, but is not limited to:

(1) Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the Limiting Age), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by any of the foregoing;

(2) In the case of coverage offered through a health maintenance organization, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual);

(3) In the case of coverage offered through a health maintenance organization, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual) and no other benefit package is available to the individual; and

(4) A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes that individual.

b) Termination of employer contributions. In the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions of this paragraph are satisfied at the time employer contributions towards the employee's or dependent's coverage terminate. Employer contributions include contributions by any current or former employer that was contributing to coverage for the employee or dependent.

c) Exhaustion of COBRA continuation coverage. In the case of an employee or dependent who has coverage that is COBRA continuation coverage, the conditions of this paragraph are satisfied at the time the COBRA continuation coverage is exhausted. For purposes of this paragraph, an individual who satisfies the conditions for special enrollment of paragraph B.3.a.3)a) of this section, does not enroll, and instead elects and exhausts COBRA continuation coverage satisfies the conditions of this paragraph.

d) Written statement. The Group or CareFirst may require an employee declining coverage (for the employee or any dependent of the employee) to state in writing whether the coverage is being declined due to other health coverage only if, at or before the time the employee declines coverage, the employee is provided with notice of the requirement to provide the statement (and the

consequences of the employee's failure to provide the statement). If the Group or CareFirst requires such a statement, and an employee does not provide it, the Group and CareFirst are not required to provide special enrollment to the employee or any dependent of the employee under this paragraph. The Group and CareFirst must treat an employee as having satisfied the requirement permitted under this paragraph if the employee provides a written statement that coverage was being declined because the employee or dependent had other coverage; the Group and CareFirst cannot require anything more for the employee to satisfy this requirement to provide a written statement. (For example, the Group and CareFirst cannot require that the statement be notarized.)

b. Special enrollment with respect to certain dependent beneficiaries:

1) Provided the Group provides coverage for dependents, CareFirst will permit the individuals described in paragraph 2), of this section to enroll for coverage in a benefit package under the terms of the Group's plan, without regard to the dates on which an individual would otherwise be able to enroll under this Evidence of Coverage.

2) Individuals eligible for special enrollment. An individual is described in this paragraph if the individual is otherwise eligible for coverage in a benefit package under the Group's plan and if the individual is described in paragraph B.3.a.2)a), b), c), d), e), or f) of this section.

a) Current employee only. A current employee is described in this paragraph if a person becomes a dependent of the individual through marriage, birth, adoption, or placement for adoption.

b) Spouse of a participant only. An individual is described in this paragraph if either:

(1) The individual becomes the spouse of a participant; or

(2) The individual is a spouse of a participant and a child becomes a dependent of the participant through birth, adoption, or placement for adoption.

c) Current employee and spouse. A current employee and an individual who is or becomes a spouse of such an employee, are described in this paragraph if either:

(1) The employee and the spouse become married; or

(2) The employee and spouse are married and a child becomes a dependent of the employee through birth, adoption, or placement for adoption.

d) Dependent of a participant only. An individual is described in this paragraph if the individual is a dependent of a participant and the individual has become a dependent of the participant through marriage, birth, adoption, or placement for adoption.

e) Current employee and a new dependent. A current employee and an individual who is a dependent of the employee, are described in this paragraph if the individual becomes a dependent of the

employee through marriage, birth, adoption, or placement for adoption.

f) Current employee, spouse, and a new dependent. A current employee, the employee's spouse, and the employee's dependent are described in this paragraph if the dependent becomes a dependent of the employee through marriage, birth, adoption, or placement for adoption.

c. Special enrollment regarding Medicaid and Children's Health Insurance Program (CHIP) termination or eligibility:

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

1) Termination of Medicaid or CHIP coverage. The employee or dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or under a state child health plan under Title XXI of such Act and coverage of the employee or dependent under such a plan is terminated as a result of loss of eligibility for such coverage.

2) Eligibility for employment assistance under Medicaid or CHIP. The employee or dependent becomes eligible for premium assistance, with respect to coverage under this Evidence of Coverage, under Medicaid or a state child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan).

MEDICAL CHILD SUPPORT ORDERS

A **Definitions**

1. 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.

    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.

2. Qualified Medical Support Order (QMSO) means a MCSO issued under State law, or the laws of the District of Columbia and, when issued to an employer sponsored health plan, one that complies with The Child Support Performance and Incentive Act of 1998, as amended.

B. **Eligibility and Termination**

1. Upon receipt of an MCSO/QMSO, when coverage of the Subscriber's family members is available under this Evidence of Coverage, CareFirst will accept enrollment of the child subject to the MCSO/QMSO submitted by the Subscriber, regardless of enrollment period restrictions. If the Subscriber does not enroll the child, CareFirst will accept enrollment from the non-Subscriber custodial parent, or the appropriate child support enforcement agency of any state or the District of Columbia. If the Subscriber has not completed an applicable Waiting Period for coverage, the child subject to the MCSO/QMSO will not be enrolled until the end of the Waiting Period.

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

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.

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

    e. Does not reside in the Service Area.

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

   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 effective date of the termination of coverage; or

   c. The Group has eliminated family member's coverage for all its employees; or

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

C. **Administration**

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

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

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

3. Provide benefits directly to:

   a. The non-insuring parent;

   b. The Health Care Provider of the Covered Services; or

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

TERMINATION OF COVERAGE

A. **Disenrollment of Individual Members**

The Group has the sole and complete authority to make determinations regarding eligibility and termination of coverage in the Plan.

The Group Health Plan will not rescind coverage under the Plan with respect to an individual (including a group to which the individual belongs or family coverage in which the individual is included) once the individual is covered under the Plan, unless the individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or unless the individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the Plan. The Group Health Plan will provide at least thirty (30) days advance written notice to each participant who would be affected before coverage is rescinded regardless of whether the Rescission applies to an entire group or only to an individual within the group.

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

1. CareFirst may terminate a Member's coverage for nonpayment of charges when due, by the Group.

2. The Group is required to terminate a Member's coverage if the individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or if the individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the Plan.

3. The Group is required to terminate the Subscriber's coverage and the coverage of the Dependents, if applicable, if the Subscriber no longer meets the Group's eligibility requirements for coverage.

4. The Group is required to terminate a Member's coverage if the Member no longer meets the Group's eligibility requirements for coverage.

5. The Group is required to notify the Subscriber if a Member's coverage is cancelled. If the Group does not notify the Subscriber, this will not continue the Member's coverage beyond the termination date of coverage. The Member's coverage will terminate on the termination date set forth in the Eligibility Schedule.

6. Except in the case of a Dependent child enrolled pursuant to an MCSO or QMSO, coverage of any Dependents, if Dependent coverage is available, will terminate if the Subscriber changes the Type of Coverage to an Individual or other non-family contract.

B. **Death of a Subscriber**

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

C. **Effect of Termination**

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

D. **Reinstatement**

Coverage will not reinstate automatically under any circumstances.

CONTINUATION OF COVERAGE

A. **Continuation of Eligibility upon Loss of Group Coverage**

1. **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.

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

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

B. **Extension of Benefits**
During an extension period under this Evidence of Coverage, premium may not be charged. Benefits will cease as of 11:59 p.m., Eastern Standard Time, on the Subscriber's termination date.

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

2. This extension of benefits will not apply if:

   a. Coverage is terminated for non-payment of the required premium by the Member;

   b. Coverage is terminated for fraud or material misrepresentation by the Member; or

   c. The member obtained uninterrupted and comparable coverage under a succeeding vision plan that is less than the cost to the Member of the extended benefit.

COORDINATION OF BENEFITS

A. Coordination of Benefits

1. Applicability

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

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

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

2) May be reduced when, under the order of determination rules, another Plan determines its benefits first. The above reduction is explained in the Effect on the Benefits section of this CareFirst Plan Evidence of Coverage.

2. 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 is covered in whole or in part by any of the Plans covering the Member. This means that any expense or portion of an expense that is 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 that specifically designated health care facility of a hospital that provides the highest level of care and which is restricted to those patients who are physically, critically ill or injured.

Plan means any health insurance policy, including those of nonprofit health service Plan and those of commercial group, blanket, and individual policies, any subscriber contracts issued by health maintenance organizations, and any other established programs under which the insured may make a claim. The term Plan includes coverage required or provided by law or coverage under a governmental Plan, except a governmental plan which, by law, provides benefits that are 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:

a. An individually underwritten and issued, guaranteed renewable, specified disease policy, or specified accident policy;

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

c. Coverage regulated by a motor vehicle reparation law;

d. Any hospital indemnity or other fixed indemnity coverage contract;

e. An elementary and/or secondary school insurance program sponsored by a school or school system and any school accident-type coverage that covers for accidents only, including athletics injuries;

f. Medicare supplemental policies;

g. Limited benefit health coverage as defined by state law;

h. Long-term care insurance policies for non-medical services;

i. Personal Injury Protection (PIP) benefits under a motor vehicle liability insurance policy.

j. A state plan under Medicaid; or

k. A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan.

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.

a. 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.

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

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

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

3. **Order of Benefit Determination Rules**

a. **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:

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

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

b. **Rules**

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

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

   a) Secondary to the Plan covering the person as a dependent; and

   b) 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.

2) 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:

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

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

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

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

      (1) If the specific terms of a court decree state that 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 3.b.2)a) above also shall apply if: i) a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, or ii) a court decree states that the parents have joint custody without

specifying that one parent has responsibility for the health care expenses or coverage of the dependent child.

(2) 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:

(a) The Plan of the parent with custody of the child;

(b) The Plan of the spouse of the parent with the custody of the child;

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

(d) The Plan of the spouse of the parent who does not have custody of the child.

c) 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.

3) 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.

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

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

b) 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.

5) 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.

4. **Effect on the Benefits of this CareFirst Plan**

a. **When this Section Applies**
This section applies when, in accordance with the prior section, order of benefits determination rules, this CareFirst Plan is a Secondary Plan as to one or more other Plans. In that event the benefits of this CareFirst Plan may be reduced

under this section. Such other Plan or Plans are referred to as "the other Plans" immediately below.

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

5. **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.

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

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

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

b. Insurance companies; or

c. Other organizations.

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

B. **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:

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

2. 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.

HOW THE PLAN WORKS

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

A. **Appropriate Care and Medical Necessity**

CareFirst works to make sure that health care is rendered in the most appropriate setting and in the most appropriate way. While ensuring that the Member receives the best care, this also helps to control health care costs. In order to make sure that the setting and treatment are appropriate, some Covered Services require review before a Member receives care. These services are marked throughout this Evidence of Coverage.

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

B. **Choosing a Provider**

1. Member/Health Care Provider Relationship

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

   b. CareFirst makes payment for Covered Services, but does not provide these services. CareFirst is not liable for any act or omission of any Health Care Provider.

2. Participating Provider; In-Network Providers

   a. Claims will be submitted directly to CareFirst by the Participating Provider.

   b. CareFirst will pay benefits directly to the Participating Provider.

   c. The Member is responsible for any applicable Deductible and Coinsurance or Copayment and balance due after CareFirst's payment unless otherwise stated.

3. Non-Participating Provider; Out-of-Network Providers

   a. Claims may be submitted directly to CareFirst or its designee by the Non-Participating Provider, or the Member may need to submit the claim. In either case, it is the responsibility of the Member to make sure that proofs of loss are filed on time.

   b. All benefits for Covered Services will be payable to the Subscriber, or to the Non-Participating Provider will be payable to the Subscriber, at the discretion of CareFirst.

   c. In the case of a Dependent child enrolled pursuant to an MCSO or a QMSO, payment will be paid directly to the State of Maryland Department of Health and

Mental Hygiene or the non-insuring parent if proof is provided that such parent has paid the Non-Participating Provider.

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

C. Notice of Claim

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

D Claim Forms

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

E. Proofs of Loss

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

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

A Member's failure to furnish the proof of loss within the time required does not invalidate or reduce a claim if it was not reasonably possible to submit the proof within the required time, if the proof is furnished as soon as reasonably possible, and except in the absence of legal capacity of the Member, not later than one (1) year from the time proof is otherwise required.

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

F. Time of Payment of Claims

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

G. Claim Payments Made in Error

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

H. Assignment of Benefits

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

I. Evidence of Coverage

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

J. Notices

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

K. Privacy Statement

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

DESCRIPTION OF COVERED SERVICES

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

Benefits are available for:

1. A vision exam which may include:
    a. Case history;
    b. External exam of eye and adnexa;
    c. Ophthalmoscopic exams;
    d. Determination of refractive status;
    e. Binocular balance test;
    f. Tonometry test for glaucoma;
    g. Gross visual fields;
    h. Color vision test;
    i. Summary finding;
    j. Recommendations, including prescription of corrective lenses.
2. Prescribed frames and lenses or contact lenses including directly related Health Care Provider services such as:
    a. Measurement of face and interpupillary distance;
    b. Quality assurance;
    c. Reasonable aftercare to fit, adjust, and maintain comfort and effectiveness;
    d. Help in choosing frames.
4. One pair of frames.
5. One pair of prescription lenses:
    a. Single or multi vision;
    b. Tinted; or
    c. Sunglasses.

6. One pair of prescription contact lenses, or multiple pairs of prescription contact lenses if the Member selects disposable contact lenses.

   a. When Medically Necessary as a result of cataract surgery; or when visual acuity of at least 20/70 in the better eye can be obtained only by use of contact lenses.

      The Member must obtain prior authorization by contacting CareFirst at the telephone number on the Member's identification card.

   b. At the election of the Member (in place of frames and lenses).

EXCLUSIONS

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

CareFirst will not provide a benefit for:

- Any service, supply or item that is not Medically Necessary. Although a service may be listed as covered, benefits will be provided only if the service is Medically Necessary as determined by CareFirst.

- Services that are Experimental/Investigational or not in accordance with accepted medical standards in effect at the time the service in question is rendered, as determined by CareFirst.

- Services or supplies received at no charge to a Member in any federal hospital, or through any federal, state or local governmental agency or department, or not the legal obligation of the Member, or where the charge is made only to insured persons.

  This exclusion does not apply to:

  1. Medicaid;

  2. Benefits provided in any state, county, or municipal hospital in or out of the state of Maryland;

  3. Care received in a Veteran's hospital unless the care is rendered for a condition that is a result of a Member's military service.

- Services that are not specifically shown in this Evidence of Coverage as a Covered Service or that do not meet all other conditions and criteria for coverage, as determined by CareFirst. Provision of services, even if Medically Necessary, by a Participating Provider does not, by itself, entitle a Member to benefits if the services are excluded or do not otherwise meet the conditions and criteria for coverage.

- Cosmetic services.

- Treatment rendered by a Health Care Provider who is the Member's parent, child, grandparent, grandchild, sister, brother, great grandparent, great grandchild, aunt, uncle, niece, or nephew or resides in the Member's home.

- All non-prescription drugs, medications, biologicals, and Over-the-Counter disposable supplies, routinely obtained and self-administered by the Member, except as stated in the Description of Covered Services.

- Services furnished as a result of a referral prohibited by law.

- Non-medical, Health Care Provider services, including, but not limited to:

  1. Telephone consultations, charges for failure to keep a scheduled visit, completion of forms, copying charges or other administrative services provided by the Health Care Provider or his/her staff.

  2. Administrative fees charges by a Health Care Provider to a Member to retain the Health Care Provider's medical practices services, e.g., "concierge fees" or boutique medical practice membership fees. Benefits under this Evidence of Coverage are limited to Covered Services rendered to a Member by a Health Care Provider.

- Services related to an excluded service (even if those services or supplies would otherwise be Covered Services).

- Separate billings for health care services or supplies furnished by an employee of a Health Care Provider which are normally included in the Health Care Provider's charges and billed for by them.

- Services that are non-medical in nature, including, but not limited to personal hygiene, Cosmetic and convenience items, including, but not limited to, air conditioners, humidifiers, exercise equipment, elevators or ramps.

- Personal comfort items.

- Services performed or prescribed by or under the direction of a person who is not a Health Care Provider.

- Services performed or prescribed by or under the direction of a person who is acting beyond his/her scope of practice.

- Services provided through a dental or medical department of an employer; a mutual benefit association, a labor union, a trust, or a similar entity.

- Services rendered or available under any Workers' Compensation or occupational disease, or employer's liability law, or any other similar law, even if a Member fails to claim benefits. Exclusions to these laws exist for partnerships, sole proprietorships and officers of closed corporations. If a Member is exempt from the above laws, the benefits of this Evidence of Coverage will be provided for Covered Services.

- Services provided or available through an agent of a school system in response to the requirements of the Individuals With Disabilities Education Act and Amendments, or any similar state or federal legislation mandating direct services to disabled students within the educational system, even when such services are of the nature that they are Covered Services when provided outside the educational domain.

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

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

- Charges used to satisfy a Member's vision care benefits deductible, if applicable, or balances from any such programs.

- Medical or surgical treatment of myopia or hyperopia. Coverage is not provided for radial keratotomy and any other forms of refractive keratoplasty, or any complications.

- Financial and/or legal services.

The following exclusions are specific to the corresponding services listed in the Description of Covered Services.

CareFirst will not provide a benefit for:

1. Diagnostic services, except as may be necessary for a vision exam.

2. Medical care or surgery.

3. Prescription Drugs, except as may be necessary for a vision exam.

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

5. Except as otherwise provided, vision care services for Cosmetic use.

6. Replacement, within the same Benefit Period, of frames, lenses or contact lenses that were lost or broken.

7. Non-prescription glasses, sunglasses or contact lenses.

8. Services or supplies for which prior authorization is required but not obtained.

ELIGIBILITY SCHEDULE

ELIGIBLE FOR COVERAGE		
The following persons meeting the eligibility requirements established by the Group are eligible for benefits under this Evidence of Coverage:		
Subscriber	A person eligible under guidelines defined by the Group, including: • Non-Medicare-eligible retiree under the terms of the Group's retirement program, as amended from time to time who was covered as a wage-earning employee before retirement.	
Spouse	Coverage for a Dependent spouse is available.	
Domestic Partner	Coverage for Domestic Partners is not available.	
Dependent children	Coverage for Dependent children, excluding children of a Domestic Partner, is available.	**Limiting Age** Up to age 26
Unmarried, incapacitated Dependent children	A Dependent child covered under this Evidence of Coverage will be eligible for coverage past the Limiting Age if: 1. The Dependent child is chiefly dependent for support upon the Subscriber or the Subscriber's Dependent spouse; and 2. At the time of reaching the Limiting Age, is incapable of self-support because of mental or physical incapacity that started before the Dependent child attained the Limiting Age. 3. The Subscriber provides the Group (or CareFirst if the Group so elects) with proof of the Dependent child's mental or physical incapacity within thirty (30) days after the Dependent child's coverage would otherwise terminate. The Group has the right to determine whether the child is and continues to qualify as mentally or physically incapacitated.	**Limiting Age** Not applicable
Individuals covered under prior continuation provision	Coverage for a person whose coverage was being continued under a continuation provision of the Group's prior health insurance plan is available.	
	Coverage for a person whose coverage was being continued under a continuation provision of the Subscriber's prior health insurance plan is available.	

EFFECTIVE DATES OF COVERAGE	
Open Enrollment	Coverage is effective on the Group's Contract Date.
Newly eligible Subscriber	A newly eligible Subscriber must apply for coverage under this Evidence of Coverage during the enrollment period defined by the Group and is effective on the date defined by the Group. A Subscriber who is not enrolled when the Group receives a QMSO is eligible for coverage effective on the date specified in the MCSO.
Dependents of a newly eligible Subscriber	Dependents of a newly eligible Subscriber must apply for coverage under this Evidence of Coverage during the enrollment period defined by the Group and is effective on the date defined by the Group.
Newly eligible Dependents of a Subscriber	Newly eligible Dependents of a Subscriber must apply for coverage under this Evidence of Coverage as stated in the Special Enrollment Periods section of this Eligibility Schedule. Coverage for such newly eligible Dependents will be effective as stated in the Special Enrollment Periods section of this schedule.
Individuals whose coverage was being continued under the Group's prior health insurance plan	Coverage is effective on the Group's Contract Date
Dependents of the individual being continued under the individual's prior health insurance plan	Coverage is effective as stated in "Dependents of a newly eligible Subscriber."

SPECIAL ENROLLMENT PERIODS			
Special Enrollment Event:		**The employee must notify the Group, and the Group must notify CareFirst:**	**Effective Date of Coverage for Special Enrollment events:**
Special enrollment for certain individuals who lose coverage (not applicable to retirees)		No later than thirty (30) days after the exhaustion of the other coverage described or termination of the other coverage as a result of the loss of eligibility for the other coverage described or following the termination of employer contributions toward that other coverage. However, in the case of loss of eligibility for coverage due to the operation of a lifetime limit on all benefits, the Group and CareFirst will allow the employee a period of at least thirty (30) days after a claim is denied due to the operation of a lifetime limit on all benefits.	The first (1st) of the month following acceptance of the enrollment by CareFirst.
Special enrollment for certain dependent beneficiaries	In the case of marriage:	Within thirty-one (31) from date of marriage.	The date of marriage.
	In the case of a newly born child:	Within thirty-one (31) from date of birth.	The date of birth.
	In the case of an adopted child:	Within thirty-one (31) from date of adoption which is the earlier of the date a judicial decree of adoption is signed; or the assumption of custody, pending adoption, of a prospective adoptive child by a prospective adoptive parent.	The date of adoption.
Special enrollment regarding Medicaid and CHIP termination or eligibility		No later than sixty (60) days after the date the employee or dependent is terminated as a result of loss of eligibility for coverage under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act, Or, No later than sixty (60) days after the date the employee or dependent is determined to be eligible for	The date coverage terminated as a result of loss of eligibility for coverage under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act; or the date eligible for premium assistance with respect to coverage under this Evidence of Coverage, under Medicaid or a State child health plan.

	premium assistance, with respect to coverage under this Evidence of Coverage, under Medicaid or a State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan).	

TERMINATION OF COVERAGE		
If the Member is a:		**Date of Termination of Coverage:**
Subscriber no longer eligible	A Subscriber and his/her Dependents will remain covered until:	The end of the month the Subscriber's eligibility ceases as determined by the Group.
Dependent spouse no longer eligible	A Dependent spouse will remain covered until:	The end of the month the Subscriber's eligibility ceases as determined by the Group.
Dependent child	A Dependent child will remain covered until:	The end of the month when eligibility ceases as determined by the Group.
If the reason for termination is:		**Date of Termination of Coverage:**
Nonpayment by the Group	The Member will remain covered until:	The date stated in CareFirst's written notice of termination.
Fraud or intentional misrepresentation of material fact	The Member will remain covered until:	The date stated in CareFirst's and/or the Group's written notice of termination.
Changes to the Type of Coverage from Individual and Child, Individual and Adult, or Family Type of Coverage to Individual Type of Coverage (except in the case of a Dependent child enrolled pursuant to a court or administrative order or QMSO)	Dependents will remain covered until:	The end of the month the Subscriber changes the Type of Coverage to Individual Type of Coverage.
Death of a Subscriber	Dependents will remain covered until:	The date determined by the Group.

SCHEDULE OF BENEFITS

CareFirst pays (on the Plan's behalf) only for Covered Services. Services that are not listed in the Description of Covered Services, or are listed in Exclusions, are not Covered Services.

The Member pays for services, supplies, or care which is not covered. The Member pays any applicable Deductible, and Coinsurance or Copayment.

When determining the benefits a Member may receive, CareFirst considers all provisions of this Evidence of Coverage, its medical policies, and its operating procedures.

Unless otherwise stated for a particular Covered Service during a Benefit Period:

<table>
<tr><th rowspan="2">Covered Service</th><th colspan="2">In-Network</th><th>Out-of-Network</th></tr>
<tr><th>CareFirst Payment</th><th>Member Payment</th><th>CareFirst Reimbursement to Member</th></tr>
<tr><td>Vision Exam
(including dilation)</td><td colspan="3"></td></tr>
<tr><td>Optometrist</td><td>Up to $50</td><td>Balance after CareFirst's payment</td><td>Member pays total charge and CareFirst reimburses Member up to $50</td></tr>
<tr><td>Ophthalmologist</td><td>$66</td><td>Balance after CareFirst's payment</td><td>Member pays total charge and CareFirst reimburses Member up to $66</td></tr>
<tr><td>Frames
and
Spectacle Lenses
Basic Lenses</td><td colspan="3">Important note regarding Member Payments
"Basic" means lenses with no "add-ons" such as scratch-resistant/ UV coating, progressive/transitional lenses, etc. "Add-ons" are not Covered Services under this Evidence of Coverage.</td></tr>
<tr><td>Frames</td><td>Up to $40</td><td>Balance after CareFirst's payment</td><td>Member pays total charge and CareFirst reimburses Member up to $40</td></tr>
<tr><td>Basic single vision</td><td>Up to $40</td><td rowspan="4">Balance after CareFirst's payment</td><td>Member pays total charge and CareFirst reimburses Member up to $40</td></tr>
<tr><td>Basic bifocal</td><td>Up to $70</td><td>Member pays total charge and CareFirst reimburses Member up to $70</td></tr>
<tr><td>Basic trifocal</td><td>Up to $90</td><td>Member pays total charge and CareFirst reimburses Member up to $90</td></tr>
<tr><td>Lenticular eyeglass</td><td>Up to $40</td><td>Member pays total charge and CareFirst reimburses Member up to $240*

*post-cataract eyeglass</td></tr>
<tr><td>Elective
Contact Lenses
(limited to contact lenses from a CareFirst designated collection)</td><td>Up to $80</td><td>Balance after CareFirst's payment</td><td>No benefit</td></tr>
<tr><td>Medically Necessary
Contact Lenses</td><td>Up to $230 with prior approval</td><td>Balance after CareFirst's payment</td><td>Member pays total charge and CareFirst reimburses Member up to $230</td></tr>
</table>

CLAIMS PROCEDURES
Internal claims and Appeals and External Review processes

The Plan's Claims Procedures were developed in accordance with section 503 of the Employee Retirement Income Security Act of 1974 (ERISA or the Act), 29 U.S.C. 1133, 1135, which sets forth minimum requirements for employee benefit plan procedures pertaining to Claims for Benefits by Members as required by 29 CFR 2560.503-1 (the DOL claims procedure regulation), and the Public Health Service Act (PHS Act) requirements with respect to internal claims and Appeals and External Review processes for Group Health Plans that are not grandfathered health plans under §2590.715–1251 as set forth in §2590.715-2719. Except as otherwise specifically provided, these requirements apply to every employee benefit plan described in section 4(a) and not exempted under section 4(b) of the Act. Notwithstanding this provision, nothing herein shall be construed to mean or imply that a non-ERISA Group Health Plan has deemed itself subject to ERISA.

A. DEFINITIONS

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

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

Appeal (or Internal Appeal) means review by the Plan or the Plan's Designee of an Adverse Benefit Determination, as required in paragraph E. of this section.

Claim Involving Urgent Care is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

1. Could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function, or,

2. In the opinion of a physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

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

Claimant means an individual who makes a claim under this section. For purposes of this section, references to claimant include a claimant's authorized representative.

External Review means a review of an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) conducted pursuant to the External Review process of paragraph K of this section.

Final External Review Decision, as used in paragraph K. of this section, means a determination by an Independent Review Organization at the conclusion of an External Review.

Final Internal Adverse Benefit Determination means an Adverse Benefit Determination that has been upheld by the Plan or the Plan's Designee at the completion of the Internal Appeals process applicable under paragraph E. of this section (or an Adverse Benefit Determination with respect to which the Internal Appeals process has been exhausted under the deemed exhaustion rules of paragraph E.3 of this section).

Group Health Plan means an employee welfare benefit Plan within the meaning of section 3(1) of the Act to the extent that such Plan provides "medical care" within the meaning of section 733(a) of the Act.

Health Care Professional means a physician or other Health Care Professional licensed, accredited, or certified to perform specified health services consistent with State law.

Independent Review Organization (or IRO) means an entity that conducts independent External Reviews of Adverse Benefit Determinations and Final Internal Adverse Benefit Determinations pursuant to paragraph K. of this section.

NAIC Uniform Model Act means the Uniform Health Carrier External Review Model Act promulgated by the National Association of Insurance Commissioners in place on July 23, 2010.

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

Plan means that portion of the Group Health Plan established by the Group that provides for health care benefits for which CareFirst is the claims administrator under this Group Contract.

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

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

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

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

1. Was relied upon in making the benefit determination;

2. Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination;

3. Demonstrates compliance with the administrative processes and safeguards required pursuant to these Claims Procedures in making the benefit determination; or

4. Constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the Claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

B. CLAIMS PROCEDURES

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

These Claims Procedures do not preclude an authorized representative of a Claimant from acting on behalf of such Claimant in pursuing a benefit claim or Appeal of an Adverse Benefit Determination. Nevertheless, the Plan has established reasonable procedures for determining whether an individual has been authorized to act on behalf of a Claimant, provided that, in the case of a Claim Involving Urgent Care, a Health Care Professional, with knowledge of a Claimant's medical condition shall be permitted to act as the authorized representative of the Claimant.

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

C. CLAIMS PROCEDURES COMPLIANCE

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

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

   a. Is a communication by a Claimant or an authorized representative of a Claimant that is received by the person or organizational unit designated by the Plan or Plan Designee that handles benefit matters; and

   b. Is a communication that names a specific Claimant; a specific medical condition or symptom; and a specific treatment, service, or product for which approval is requested.

2. Civil Action. A Claimant is not required to file more than the Appeals process described herein prior to bringing a civil action under ERISA.

D. CLAIM FOR BENEFITS

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

E. TIMING OF NOTIFICATION OF BENEFIT DETERMINATION (Internal claims and Appeal process)

1. In general. Except as provided in paragraph E.2, if a claim is wholly or partially denied, the Claimant shall be notified in accordance with paragraph F. herein, of the Adverse Benefit Determination within a reasonable period of time, but not later than ninety (90) days after receipt of the claim by the Plan or the Plan's Designee, unless it is determined that special circumstances require an extension of time for processing the claim. If it is determined that an extension of time for processing is required, written Notice of the extension shall be furnished to the Claimant prior to the termination of the initial ninety (90)-day period. In no event shall such extension exceed a period of ninety (90) days from the end of such initial period. The extension Notice shall indicate the special circumstances requiring an extension of time and the date by which the benefit determination will be rendered.

2. The Claimant shall be notified of the determination in accordance with the following, as appropriate.

    a. Expedited Notification of benefit determinations involving urgent care. In the case of a Claim Involving Urgent Care, the Claimant shall be notified of the benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after receipt of the claim unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Claimant shall be notified as soon as possible, but not later than twenty-four (24) hours after receipt of the claim, of the specific information necessary to complete the claim. The Claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the specified information. Notification of any Adverse Benefit Determination pursuant to this paragraph shall be made in accordance with paragraph F. herein. The Claimant shall be notified of the benefit determination as soon as possible, but in no case later than forty-eight (48) hours after the earlier of:

        1) Receipt of the specified information, or

        2) The end of the period afforded the Claimant to provide the specified additional information.

    b. Concurrent care decisions. If an ongoing course of treatment has been approved to be provided over a period of time or number of treatments:

        1) Any reduction or termination of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments shall constitute an Adverse Benefit Determination. The Claimant shall be notified in accordance with paragraph F. herein, of the Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to Appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated.

2) Any request by a Claimant to extend the course of treatment beyond the period of time or number of treatments that is a Claim Involving Urgent Care shall be decided as soon as possible, taking into account the medical exigencies. The Claimant shall be notified of the benefit determination, whether adverse or not, within twenty-four (24) hours after receipt of the claim, provided that any such claim is made at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments. Notification of any Adverse Benefit Determination concerning a request to extend the course of treatment, whether involving urgent care or not, shall be made in accordance with paragraph F. herein, and Appeal shall be governed by paragraphs H.2.a, H.2.b, or H.2.c, herein as appropriate.

3) Continued coverage will be provided pending the outcome of an Appeal.

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

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

2) Post-Service Claims. In the case of a Post-Service Claim, the Claimant shall be notified, in accordance with paragraph F. herein, of the Adverse Benefit Determination within a reasonable period of time, but not later than thirty (30) days after receipt of the claim. This period may be extended one time for up to fifteen (15) days, provided that the Plan or the Plan's Designee both determines that such an extension is necessary due to matters beyond its control and notifies the Claimant, prior to the expiration of the initial thirty (30)-day period, of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the Notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least forty-five (45) days from receipt of the Notice within which to provide the specified information.

d. Calculating time periods. For purposes of paragraph E. herein the period of time within which a benefit determination is required to be made shall begin at the time a claim is filed, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended as permitted pursuant to paragraph E.2.c above due to a Claimant's failure

to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the Notification of the extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information.

3. Deemed exhaustion of internal claims and Appeals processes. If the Plan or the Plan's Designee fails to strictly adhere to all the requirements of this paragraph E. with respect to a claim, the Claimant is deemed to have exhausted the internal claims and Appeals process, except as provided in paragraph two below. Accordingly, the Claimant may initiate an External Review under paragraph K. of this section. The Claimant is also entitled to pursue any available remedies under section 502(a) of ERISA or under State law, as applicable, on the basis that the Plan or the Plan's Designee has failed to provide a reasonable internal claims and Appeals process that would yield a decision on the merits of the claim. If a Claimant chooses to pursue remedies under section 502(a) of ERISA under such circumstances, the claim or Appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

   Notwithstanding paragraph 3 of this section, the internal claims and Appeals process of this paragraph will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the Claimant so long as the Plan or the Plan's Designee demonstrates that the violation was for good cause or due to matters beyond the control of the Plan or the Plan's Designee and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan or the Plan's Designee and the Claimant. This exception is not available if the violation is part of a pattern or practice of violations by the Plan or the Plan's Designee. The Claimant may request a written explanation of the violation from the Plan or the Plan's Designee, and the Plan or the Plan's Designee must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and Appeals process of this paragraph to be deemed exhausted. If an external reviewer or a court rejects the Claimant's request for immediate review under paragraph 3 of this section on the basis that the Plan or the Plan's Designee met the standards for the exception under this paragraph, the Claimant has the right to resubmit and pursue the internal Appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed ten (10) days), the Plan or the Plan's Designee shall provide the Claimant with Notice of the opportunity to resubmit and pursue the internal Appeal of the claim. Time periods for re-filing the claim shall begin to run upon Claimant's receipt of such Notice.

F. MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION

1. Except in the case of an Adverse Benefit Determination concerning a Claim Involving Urgent Care, the Plan or the Plan's Designee shall provide a Claimant with written or electronic Notification of any Adverse Benefit Determination. The Notification shall set forth, in a manner calculated to be understood by the Claimant:

   a. The specific reason or reasons for the adverse determination;

   b. Reference to the specific Plan provisions on which the determination is based;

   c. A description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary;

   d. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil

action under section 502(a) of the Act following an Adverse Benefit Determination on review;

e. In the case of an Adverse Benefit Determination:

1) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request; or

2) If the Adverse Benefit Determination is based on a Medical Necessity or Experimental/Investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

f. In the case of an Adverse Benefit Determination by the Plan or the Plan's Designee concerning a Claim Involving Urgent Care, a description of the expedited review process applicable to such claims.

2. In the case of an Adverse Benefit Determination by the Plan or the Plan's Designee concerning a Claim Involving Urgent Care, the information described above may be provided to the Claimant orally within the time frame prescribed in paragraph E.2.a herein, provided that a written or electronic Notification in accordance with paragraph F.1 of this section is furnished to the Claimant not later than three (3) days after the oral Notification.

Notice will be provided in accordance with paragraph J., herein.

G. APPEAL OF ADVERSE BENEFIT DETERMINATIONS

1. To Appeal a denied claim, a written request and any supporting record of medical documentation must be submitted to the address on the reverse side of your membership card within one-hundred and eighty (180) days of the Adverse Benefit Determination.

2. a. A Claimant has the opportunity to submit written comments, documents, records, and other information relating to the Claim for Benefits;

b. A Claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant to the Claimant's Claim for Benefits;

c. The Plan or the Plan's Designee shall take into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

3. In addition to the requirements of paragraphs G.2.a through c herein, the following apply:

a. The Plan or the Plan's Designee shall provide for a review that does not afford deference to the initial Adverse Benefit Determination and will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the Appeal, nor the subordinate of such individual;

b. In deciding an Appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental/ Investigational, or not Medically Necessary or appropriate, the appropriate named fiduciary shall consult with a Health Care Professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

c. Upon request, the Plan or the Plan's Designee will identify medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination;

d. Health Care Professionals engaged for purposes of a consultation under paragraph G.3.b herein shall be individuals who were neither consulted in connection with the Adverse Benefit Determination that is the subject of the Appeal, nor subordinates of any such individuals; and

e. In the case of a Claim Involving Urgent Care, a request for an expedited Appeal of an Adverse Benefit Determination may be submitted orally or in writing by the Claimant; and all necessary information, including the Plan's or the Plan Designee's determination on review, may be transmitted between the Plan or the Plan's Designee and the Claimant by telephone, facsimile, or other available similarly expeditious method.

4. Full and fair review. The Plan or the Plan's Designee shall allow a Claimant to review the claim file and to present evidence and testimony as part of the internal claims and Appeals process. Specifically, in addition to the requirements of paragraphs G.2.a through c herein, the following apply:

   a. The Plan or the Plan's Designee shall provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan or the Plan's Designee (or at the direction of the Plan or the Plan's Designee) in connection with the claim; such evidence will be provided as soon as possible and sufficiently in advance of the date on which the Notice of Final Internal Adverse Benefit Determination is required to be provided under paragraph H. herein, to give the Claimant a reasonable opportunity to respond prior to that date; and

   b. Before the Plan or the Plan's Designee issues a Final Internal Adverse Benefit Determination based on a new or additional rationale, the Claimant shall be provided, free of charge, with the rationale; the rationale shall be provided as soon as possible and sufficiently in advance of the date on which the Notice of Final Internal Adverse Benefit Determination is required to be provided under paragraph H. herein, to give the Claimant a reasonable opportunity to respond prior to that date.

5. Avoiding conflicts of interest. In addition to the requirements of paragraphs B. and G. herein, regarding full and fair review, the Plan or the Plan's Designee shall ensure that all claims and Appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.

H. TIMING OF NOTIFICATION OF DETERMINATION OF APPEAL

1. In general. Except as provided below and in paragraph H.2, a Claimant shall be Notified in accordance with paragraph I. herein of the benefit determination on review within a reasonable period of time, but not later than sixty (60) days after receipt of the Claimant's request for review, unless it is determined that special circumstances require an extension of time for processing the claim. If it is determined that an extension of time for processing is required, written Notice of the extension shall be furnished to the Claimant prior to the termination of the initial sixty (60)-day period. In no event shall such extension exceed a period of sixty (60) days from the end of the initial period. The extension Notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan or the Plan's Designee expects to render the determination on review.

2. The Plan or the Plan's Designee shall notify a Claimant of its benefit determination on review in accordance with the following, as appropriate.

   a. Urgent care claims. In the case of a Claim Involving Urgent Care, the Claimant shall be Notified, in accordance with paragraph I. herein, of the benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after receipt of the Claimant's request for review of an Adverse Benefit Determination.

   b. Pre-service claims. In the case of a Pre-Service Claim, the Claimant shall be Notified, in accordance with paragraph I. herein, of the benefit determination on review within a reasonable period of time appropriate to the medical circumstances. Such Notification shall be provided not later than thirty (30) days after receipt of the Claimant's request for review of an Adverse Benefit Determination.

   c. Post-service claims. In the case of a Post-Service Claim, except as provided below, the Claimant shall be Notified, in accordance with paragraph I. herein, of the benefit determination on review within a reasonable period of time. Such Notification shall be provided not later than sixty (60) days after receipt of the Claimant's request for review of an Adverse Benefit Determination.

3. Calculating time periods. For purposes of paragraph H. herein, the period of time within which a benefit determination on review shall be made begins at the time an Appeal is received by the Plan or the Plan's Designee, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as permitted pursuant to paragraph I.1 herein due to a Claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the Notification of the extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information.

4. In the case of an Adverse Benefit Determination on review, upon request, the Plan or the Plan's Designee shall provide such access to, and copies of Relevant documents, records, and other information described in paragraphs I.3, I.4, and I.5 herein as is appropriate.

I. MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION ON APPEAL

The Plan or the Plan's Designee shall provide a Claimant with written or electronic Notification of its benefit determination on review. In the case of an Adverse Benefit Determination, the Notification shall set forth, in a manner calculated to be understood by the Claimant:

1. The specific reason or reasons for the adverse determination;

2. Reference to the specific Plan provisions on which the benefit determination is based;

3. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant to the Claimant's Claim For Benefits;

4. A statement describing any voluntary Appeal procedures offered by the Plan and the Claimant's right to obtain the information about such procedures, and a statement of the Claimant's right to bring an action under section 502(a) of the Act; and

5. a. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Claimant upon request;

   b. If the Adverse Benefit Determination is based on a Medical Necessity or Experimental/Investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

   c. Other information may be available regarding dispute resolutions through your local U.S. Department of Labor Office and or your State insurance regulatory agency.

Notice will be provided in accordance with paragraph J., herein.

J. NOTICE

1. Notice. The Plan or the Plan’s Designee shall provide Notice to individuals, in a culturally and linguistically appropriate manner (as described in paragraph 2. of this section) in accordance with paragraphs F. and I. herein. Additionally:

   a. The Plan or the Plan’s Designee shall ensure that any notice of Adverse Benefit Determination or Final Internal Adverse Benefit Determination includes information sufficient to identify the claim involved (including the date of service, the Health Care Provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).

   b. The Plan or the Plan’s Designee shall provide to a Claimant, as soon as practicable, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, associated with any Adverse Benefit Determination or Final Internal Adverse Benefit Determination. The Plan or the Plan’s Designee shall not consider a request for such diagnosis and treatment information, in itself, to be a request for an internal Appeal under this paragraph or an External Review under paragraph K of this section.

   c. The Plan or the Plan’s Designee shall ensure that the reason or reasons for the Adverse Benefit Determination or Final Internal Adverse Benefit Determination includes the denial code and its corresponding meaning, as well as a description of the Plan's or the Plan Designee’s standard, if any, that was used in denying the claim. In the case of a Notice of Final Internal Adverse Benefit Determination, this description must include a discussion of the decision.

d. The Plan or the Plan's Designee shall provide a description of available Internal Appeals and External Review processes, including information regarding how to initiate an Appeal.

e. The Plan or the Plan's Designee shall disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793 to assist individuals with the internal claims and Appeals and External Review processes.

2. Form and manner of Notice.

a. In general. For purposes of this section, a Group Health Plan is considered to provide Relevant Notices in a culturally and linguistically appropriate manner if the Plan or the Plan's Designee meets all the requirements of paragraph b. of this section with respect to the applicable non-English languages described in paragraph c. of this section.

b. Requirements

1) The Plan or the Plan's Designee shall provide oral language services (such as a telephone customer assistance hotline) that include answering questions in any applicable non English language and providing assistance with filing claims and Appeals (including External Review) in any applicable non-English language;

2) The Plan or the Plan's Designee shall provide, upon request, a Notice in any applicable non-English language; and

3) The Plan or the Plan's Designee shall include in the English versions of all Notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Plan or the Plan's Designee.

c. Applicable non-English language. With respect to an address in any United States county to which a Notice is sent, a non-English language is an applicable non-English language if ten percent or more of the population residing in the county is literate only in the same non-English language, as determined in guidance published by the Secretary.

K. EXTERNAL REVIEW PROCESS

Maryland Office of the Attorney General
Health Education and Advocacy Unit
200 St. Paul Place, 16th Floor
Baltimore, MD 21202
(877) 261-8807
http://www.oag.state.md.us/Consumer/HEAU.htm
heau@oag.state.md.us

Additionally, the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) may also be a helpful resource to a Claimant in need of assistance.

EBSA may be contacted at: 1-866-444-EBSA (3272) or www.askebsa.dol.gov.

3. Scope

a. In general. Subject to the suspension provision in paragraph b. of this section and except to the extent provided otherwise by the Secretary in guidance, the External Review process established pursuant to this paragraph K. applies to any Adverse Benefit Determination or Final Internal Adverse Benefit Determination, except that a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a Claimant fails to meet the requirements for eligibility under the terms of a Group Health Plan is not eligible for the External Review process under this paragraph K.

b. Suspension of general rule. Unless or until this suspension is revoked in guidance by the Secretary, with respect to claims for which External Review has not been initiated before September 20, 2011, the External Review process established pursuant to this paragraph K. applies only to:

1) An Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by the Plan or the Plan's Designee that involves medical judgment (including, but not limited to, those based on the Plan's or the Plan Designee's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a Covered Service; or its determination that a treatment is Experimental/ Investigational), as determined by the External Reviewer; and

2) A Rescission of coverage (whether or not the Rescission has any effect on any particular benefit at that time).

4. Standard External Review for self-insured group health Plans

This section sets forth procedures for standard External Review for self-insured Group Health Plans. Standard External Review is External Review that is not considered expedited (as described in paragraph 5 of this section).

a. Request for External Review. The Group Health Plan allows a Claimant to file a request for an External Review with the Plan or the Plan's Designee if the request is filed within four months after the date of receipt of a Notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination. If there is no corresponding date four months after the date of receipt of such a Notice, then the request must be filed by the first day of the fifth month following the receipt of the Notice. For example, if the date of receipt of the Notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

b. Preliminary review. Within five business days following the date of receipt of the External Review request, the Group Health Plan or the Plan's Designee shall complete a preliminary review of the request to determine whether:

1) The Claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;

2) The Adverse Benefit Determination or the final Adverse Benefit Determination does not relate to the Claimant's failure to meet the requirements for eligibility under the terms of the Group Health Plan (e.g., worker classification or similar determination);

3) The Claimant has exhausted the Plan's Internal Appeal process unless the Claimant is not required to exhaust the Internal Appeals process as described under paragraph E.3; and

4) The Claimant has provided all the information and forms required to process an External Review.

Within one business day after completion of the preliminary review, the Plan or the Plan's Designee shall issue a Notification in writing to the Claimant. If the request is complete but not eligible for External Review, such Notification shall include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such Notification shall describe the information or materials needed to make the request complete and the Plan or the Plan's Designee shall allow a Claimant to perfect the request for External Review within the four-month filing period or within the forty-eight (48)-hour period following the receipt of the Notification, whichever is later.

c. Referral to Independent Review Organization. The Group Health Plan shall assign an Independent Review Organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the External Review. Moreover, the Plan or the Plan's Designee shall take action against bias and to ensure independence. Accordingly, the Plan or the Plan's Designee shall contract with at least three IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

The contract between the Plan or the Plan's designee and an IRO, shall include the following:

1) The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the Plan.

2) The assigned IRO will timely notify the Claimant in writing of the request's eligibility and acceptance for External Review. This Notice will include a statement that the Claimant may submit in writing to the assigned IRO within ten business days following the date of receipt of the Notice additional information that the IRO must consider when conducting the External Review. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.

3) Within five business days after the date of assignment of the IRO, the Plan or the Plan's Designee shall provide to the assigned IRO the documents and any information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Failure by the Plan or the Plan's Designee to timely provide the documents and information will not delay the conduct of the External Review. If the Plan or the Plan's Designee fails to timely provide the documents and information, the assigned IRO may terminate the External Review and make a decision to reverse the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Within one business day after making the decision, the IRO shall notify the Claimant and the Plan or the Plan's Designee.

4) Upon receipt of any information submitted by the Claimant, the assigned IRO shall within one business day forward the information to the Plan or the Plan's Designee. Upon receipt of any such information, the Plan or the Plan's Designee may reconsider its Adverse Benefit Determination or Final Internal Adverse Benefit Determination that is the subject of the External Review. Reconsideration by the Plan or the Plan's Designee shall not delay the External Review. The External Review may be terminated as a result of the reconsideration only if the Plan or the Plan's Designee decides, upon completion of its reconsideration, to reverse its Adverse Benefit Determination or Final Internal Adverse Benefit Determination and provide coverage or payment. Within one business day after making such a decision, the Plan or the Plan's Designee shall provide written Notice of its decision to the Claimant and the assigned IRO. The assigned IRO shall terminate the External Review upon receipt of the Notice from the Plan or the Plan's Designee.

5) The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Plan's or the Plan Designee's internal claims and Appeals process applicable under paragraph E. of this section. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

   (a) The Claimant's medical records;

   (b) The attending health care professional's recommendation;

   (c) Reports from appropriate health care professionals and other documents submitted by the Plan or the Plan's Designee, Claimant, or the Claimant's treating provider;

   (d) The terms of the Claimant's Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;

   (e) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;

   (f) Any applicable clinical review criteria developed and used by the Plan or the Plan's Designee, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and

   (g) The opinion of the IRO's clinical reviewer or reviewers after considering the information described in this Notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

6) The assigned IRO shall provide written Notice of the final External Review decision within forty-five (45) days after the IRO receives the request for the External Review. The IRO shall deliver the Notice of final External Review decision to the Claimant and the Plan or the Plan's Designee.

7) The assigned IRO's decision Notice will contain:

(a) A general description of the reason for the request for External Review, including information sufficient to identify the claim (including the date or dates of service, the Health Care Provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);

(b) The date the IRO received the assignment to conduct the External Review and the date of the IRO decision;

(c) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

(d) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(e) A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the Group Health Plan or to the Claimant;

(f) A statement that judicial review may be available to the Claimant; and

(g) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

8) After a final External Review decision, the IRO shall maintain records of all claims and Notices associated with the External Review process for six years. An IRO shall make such records available for examination by the Claimant, Plan, or state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

d. Reversal of Plan's decision. Upon receipt of a Notice of a final External Review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan or the Plan's Designee shall immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

5. Expedited External Review for self-insured Group Health Plans

a. Request for expedited External Review. The Group Health Plan shall allow a Claimant to make a request for an expedited External Review with the Plan or the Plan's Designee at the time the Claimant receives:

1) An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the Claimant for which the timeframe for completion of an expedited Internal Appeal under paragraph E.2.a would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an expedited Internal Appeal;

2) A Final Internal Adverse Benefit Determination, if the Claimant has a medical condition where the timeframe for completion of a standard

External Review would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received Emergency Services, but has not been discharged from a facility.

b. Preliminary review. Immediately upon receipt of the request for expedited External Review, the Plan or the Plan's Designee shall determine whether the request meets the reviewability requirements set forth in paragraph K.4.b above for standard External Review. The Plan or the Plan's Designee shall immediately send a Notice that meets the requirements set forth in paragraph K.4.b above for standard External Review to the Claimant of its eligibility determination.

c. Referral to Independent Review Organization. Upon a determination that a request is eligible for External Review following the preliminary review, the Plan or the Plan's Designee will assign an IRO pursuant to the requirements set forth in paragraph K.4.c above for standard review. The Plan or the Plan's Designee shall provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, shall consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO shall review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's or the Plan Designee's internal claims and Appeals process.

d. Notice of final External Review decision. The Plan's or the Plan Designee's contract with the assigned IRO shall require the IRO to provide Notice of the final External Review decision, in accordance with the requirements set forth in paragraph K.4.c above, as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO receives the request for an expedited External Review. If the Notice is not in writing, within forty-eight (48) hours after the date of providing that Notice, the assigned IRO shall provide written confirmation of the decision to the Claimant and the Plan or the Plan's Designee.

6. An External Review decision is binding on the Plan or the Plan's Designee, as well as the Claimant, except to the extent other remedies are available under state or federal law, and except that the requirement that the decision be binding shall not preclude the Plan or the Plan's Designee from making payment on the claim or otherwise providing benefits at any time, including after a final External Review decision that denies the claim or otherwise fails to require such payment or benefits. For this purpose, the Plan or the Plan's Designee shall provide any benefits (including by making payment on the claim) pursuant to the final External Review decision without delay, regardless of whether the Plan or the Plan's Designee intends to seek judicial review of the External Review decision and unless or until there is a judicial decision otherwise.