CareFirst
Family of health care plans

CareFirst of Maryland, Inc.

Dental Care Benefits

Your Member Contract

10455 Mill Run Circle Owings
Mills, MD 21117

CUT9804-9S (8/16)

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

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

An independent licensee of the Blue Cross and Blue Shield Association

EVIDENCE OF COVERAGE

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

The Group reserves the right to change, modify, or terminate the plan, in whole or in part as provided in the Group Contract. No amendment or modification of any term or provision is valid until approved by an executive officer of CareFirst and unless the approval is endorsed on the policy and attached to the Evidence of Coverage or Group Contract.

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

Group Name: COMPASS SYSTEMS, INC.

Group Number: 0RK6

Effective Date: December 1, 2016

CareFirst of Maryland, Inc.

Chester E. Burrell
President and Chief Executive Officer

SECTION 1
DEFINITIONS

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

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

Allowed Benefit means:

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

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

For Non-Participating Dentists, the Allowed Benefit payable to a Non-Participating Dentist for a Covered Dental Service will be the lesser of (1) the Dentist's actual charge; or (2) the benefit amount, according to the CareFirst rate schedule for Non-Participating Dentists, selected by the Group, for the Covered Dental Service that applies on the date that the service is rendered. The benefit amount on the CareFirst rate schedule will be no less than the amount paid to a Preferred Dentist in the same geographic area for the same service. For a Non-Participating Dentist who is a physician, the benefit is payable to the physician if the Subscriber has given an Assignment of Benefits or, otherwise, to the Subscriber or the Non-Participating Dentist at the discretion of CareFirst. For any other Non-Participating Dentist, the benefit is payable to the Subscriber or to the Non-Participating Dentist at the discretion of CareFirst. The Subscriber is responsible for payment for services to the Non-Participating Dentist, including any applicable Deductible and Coinsurance amounts as stated in the Schedule of Benefits and for any Balance Bill amounts. The Non-Participating Dentist may bill the Subscriber directly for such amounts. It is the Subscriber's responsibility to apply any CareFirst payments to the claim from the Non-Participating Dentist.

Assignment of Benefits means the transfer of health care coverage reimbursement benefits or other rights under the Evidence of Coverage by, or on behalf of, the Member to a physician pursuant to Annotated Code of Maryland, Insurance Article §14-205.3.

Balance Bill means the difference between a Non-Participating Dentist's actual charge for a Covered Dental Service and the Allowed Benefit.

Benefit Period means the period of time during which Covered Dental Services are eligible for payment. The Benefit Period is a Contract year.

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

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

Copayment (Copay) means a fixed dollar amount that a Member must pay for certain Covered Dental Services.

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.

Covered Dental Services means Medically Necessary services or supplies listed under the Covered Dental Services section of the Description of Covered Services.

Deductible means the dollar amount of the Allowed Benefits payable during a Benefit Period for Covered Dental Services which must first be incurred by the Member before CareFirst will make payments for Covered Dental Services under this Evidence of Coverage. The dollar amount paid by the Member for a portion of a Dentist's charge that is in excess of the Allowed Benefit may not be used to satisfy the Deductible.

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

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

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

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

Emergency Oral Exam is an exam received due to a dental emergency, acute infection, or trauma to the Sound Natural Teeth.

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

Experimental or Investigational means a service or supply that is in the developmental stage or in the process of human or animal testing. Services or supplies that do not meet all five (5) of the criteria listed below are deemed to be Experimental or Investigational:

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

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

C. The technology must improve the net health outcome;

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

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

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

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

Group Contract means the agreement issued by CareFirst to the Group through which the benefits described in this Evidence of Coverage are made available. In addition to the Evidence of Coverage, the

Group Contract includes the Group Contract Application, any attachments, amendments and riders attached to the Group Contract or Evidence of Coverage and signed by an officer of CareFirst.

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

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

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

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

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:

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

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

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

D. not more costly than an alternative service or sequence of services 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 and is enrolled either as a Subscriber or Dependent, and for whom the premiums have been received by CareFirst.

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

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.

Palliative Treatment is an emergency dental procedure performed to temporarily alleviate or relieve acute pain or distress but which does not necessarily effect a definite cure.

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

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

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

Service Area means the clearly defined geographic area in which CareFirst has arranged for the provision of Covered Dental Services to be generally available and readily accessible to Members. CareFirst may amend the defined Service Area at any time by notifying the Group in writing.

The Service Area is as follows: the District of Columbia; the State of Maryland; and the following Virginia counties and cities: Arlington, Alexandria, Fairfax, City of Fairfax, Falls Church, Prince William, Manassas, Manassas Park, Loudoun and Leesburg as well as those areas contiguous to the stated Service Area in which CareFirst has contracted with providers to render services to Members.

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

Specialist means a Dentist who is certified or trained in a specific field of dentistry.

Spouse means a person who is legally married to the Subscriber under the laws of the state or jurisdiction in which the marriage was performed.

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.

Surgery means the following:

A. Generally accepted operative and cutting procedures;

B. Usual and related pre and post-operative care; and

C. Other procedures CareFirst approves.

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. In addition, some Group Contracts include other categories of coverage, such as Individual and Adult coverage, Individual and Child coverage, Individual and Child(ren), or Individual and Children coverage. The Type of Coverage available is described in the Eligibility Schedule.

Waiting Period means the period of time that must pass before an employee or Dependent is eligible to enroll under the terms of this Group Contract.

SECTION 2
ELIGIBILITY AND ENROLLMENT

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

A. The Member must be eligible for coverage--either as a Subscriber under Section 2.2, as a Spouse under Section 2.3 or as a Dependent Child under Sections 2.4 and 2.5;

B. The Member must apply for coverage by submitting an enrollment form to CareFirst during certain periods set aside for this purpose as described in Section 2.6;

C. The Group must notify CareFirst of the Member's enrollment; and

D. CareFirst must receive premium payments on the Member's behalf as required by the Group Contract.

Note: No individual is eligible under the Group coverage both as a Subscriber and as a Dependent. If both Spouses (or Domestic Partners, if applicable) are eligible for coverage under this Evidence of Coverage, they may not both have Individual and Adult coverage or Family coverage.

2.2 Eligibility as a Subscriber. To enroll as a Subscriber, a Member must meet CareFirst's basic eligibility requirements and any additional eligibility requirements that CareFirst and the Group have agreed to. These are stated in the Eligibility Schedule.

A. Basic Plan Requirements. A Subscriber must be an eligible employee of the Group. Unless otherwise provided by the Group, if a person is a director, trustee, corporate officer, outside counsel, consultant, owner or partner, a person is not eligible, unless that person is actually employed by the Group and meet the same criteria for coverage that apply to other Group employees. A person is not eligible if that person is a temporary or seasonal employee. A Subscriber must be employed by the Group on a regular, year-round basis to qualify for coverage.

B. Additional Eligibility Requirements. In addition to the basic eligibility requirements in Section 2.2.A., a Member must meet the additional eligibility requirements that are listed in the Group Contract Application. The Group is required to administer these requirements in strict accordance with the terms that have been agreed to and cannot change the requirements or make an exception unless CareFirst approves them in advance, in writing.

2.3 Eligibility of Subscriber's Spouse. If the Group has elected to include coverage for the Subscriber's Spouse under this Evidence of Coverage, as stated in the attached Eligibility Schedule, then a Subscriber may cover his or her legal Spouse as a Dependent. A Subscriber cannot cover a former Spouse if the Subscriber and former Spouse have divorced or if the marriage has been annulled.

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

A. Is:

1. The natural child, stepchild, or Adopted child of the Subscriber or the Subscriber's covered Spouse;

2. A child (including a grandchild) placed with the Subscriber or the Subscriber's covered Spouse for legal Adoption; or

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

4. A grandchild of the Subscriber or the Subscriber's covered Spouse who:

   a. is unmarried;

   b. resides with the Subscriber; and

   c. is dependent on the Subscriber or the Subscriber's covered Spouse.

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

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

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

E. Upon receipt of a MCSO/QMSO, when coverage of the Subscriber's family members is available under this Evidence of Coverage, then CareFirst will accept enrollment of the child subject to a MCSO/QMSO submitted by the Subscriber regardless of enrollment period restrictions. If the Subscriber does not attempt to enroll the child subject to a MCSO/QMSO, then CareFirst will accept enrollment from the non-Subscriber custodial parent; or, the appropriate child support enforcement agency of any State or the District of Columbia. If the Subscriber has not completed any applicable waiting periods for coverage, the child subject to a 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.

   1. Enrollment for a child subject to a MCSO/QMSO 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 or is eligible for coverage under any Medical Assistance or Medicaid program; or

      e. does not reside in the Service Area.

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

a. send the non-insuring, custodial parent ID cards, claim forms, the applicable Evidence of Coverage or Member contract and any information necessary to obtain benefits;

b. allow the non-insuring, custodial parent or a provider of a Covered Service to submit a claim without the prior approval of the Subscriber;

c. provide benefits directly to:

i. the non-insuring, custodial parent;

ii. the provider of the Covered Services; or,

iii. the appropriate child support enforcement agency of any State or the District of Columbia.

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

2.5 Limiting Age for Covered Dependent Children

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

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

1. The Dependent child is incapable of self-support or maintenance because of mental or physical incapacity;

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

3. The incapacity occurred at the time of reaching the Limiting Age listed in the Eligibility Schedule;

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

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

2.6 Timely Enrollment. An eligible individual may enroll as a Subscriber or Dependent, as applicable, during the periods of time and under the conditions described below. If the individual meets these conditions, his or her enrollment will be treated as timely enrollment. Enrollment at other times will be treated as a Special Enrollment, as described in Section 2.7 and will be subject to the conditions and limitations of that section.

A. Initial Enrollment. When the Group first offers CareFirst's coverage, there will be an initial enrollment period for eligible employees. During the initial enrollment period, an eligible employee may apply for coverage for himself or herself and his or her eligible Dependents. The effective dates of coverage are stated in the attached Eligibility Schedule under the headings Existing Subscriber Effective Date and Existing Dependent Effective Date.

B. Newly Eligible Subscriber. If an eligible employee is a new employee or a newly eligible employee of the Group, the new employee or a newly eligible employee may enroll as a Subscriber within sixty (60) days after new employee or a newly eligible employee first becomes eligible. The Effective Date for Newly Eligible Subscribers in the Group are stated in the Eligibility Schedule.

C. Newborn, Newly Adopted Child, Stepchild, Newly Eligible Grandchild or Child Subject to a MCSO/QMSO or Child for whom Guardianship Has Been Granted by Court or Testamentary Appointment. Enrollment requirements for an eligible newborn, newly adopted child, stepchild, newly eligible grandchild, child subject to a MCSO/QMSO or a child for whom guardianship is granted by court or testamentary appointment depends on the Type of Coverage that is in effect on the date of the Dependent Child's First Eligibility Date, as defined below.

D. "First Eligibility Date" means:

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

2. For a newly adopted Dependent Child, the earlier of:

   a. A judicial decree of Adoption; or

   b. Placement of the Dependent Child in the Subscriber's home as the legally recognized proposed adoptive parent.

3. For a newly eligible Dependent Child, the date the Dependent Child became a dependent of Subscriber or the Subscriber's eligible Spouse.

4. For a child subject to an MCSO/QMSO, the date the MCSO/QMSO becomes effective.

5. For a minor Dependent Child for whom guardianship has been granted by court or testamentary appointment, the date of the appointment.

E. Family Coverage. If a Subscriber already has Family coverage on the Dependent Child's First Eligibility Date, a newborn Dependent Child, newly adopted Dependent Child, newly eligible Dependent Child or a minor Dependent Child for whom guardianship is granted by court or testamentary appointment will be covered automatically as of the child's First Eligibility Date. Any Type of Coverage that is not Individual, Individual and Adult or Individual and Child is considered Family coverage.

F. Individual Coverage. If a Subscriber has Individual coverage on the Dependent Child's First Eligibility Date, the Dependent Child will be covered automatically, but only for the first thirty-one (31) days following the Dependent Child's First Eligibility Date. If a Subscriber wishes to continue coverage beyond this thirty-one (31) day period, the Subscriber must enroll the child within thirty-one (31) days following the Dependent Child's First Eligibility Date. Premium changes resulting from the addition of the Dependent Child will be effective as of the child's First Eligibility Date

G. Individual and Adult or Individual and Child Coverage. This provision applies only to Groups that offer Individual and Adult coverage or Individual and Child coverage. If a Subscriber has Individual and Adult coverage or Individual and Child coverage on the Dependent Child's First Eligibility Date, the Dependent Child will be covered automatically as of the Dependent Child's First Eligibility Date. However, if addition of the Dependent Child results in a change in the Subscriber's Type of Coverage (e.g., from Individual and Adult coverage or Individual and Child coverage to Family coverage), the Dependent Child's automatic coverage will end on the thirty-first (31st) day following the child's First Eligibility Date. If the Subscriber wishes to continue coverage beyond this thirty-one (31) day period, the Subscriber must enroll the Dependent Child within thirty-one (31) days following the First Eligibility Date. The change in Type of Coverage and corresponding premium for the Subscriber's new Type of Coverage will be made effective as of the child's First Eligibility Date.

H. Newly Eligible Dependent (Other than Newborn, Newly Adopted Child, Stepchild, Newly Eligible Grandchild or Child Subject to a MCSO/QMSO or Child for whom Guardianship Has Been Granted by Court or Testamentary Appointment). A Subscriber may enroll a newly eligible dependent, such as a new Spouse, and/or change the Subscriber's Type of Coverage to include the newly eligible dependent within thirty-one (31) days following the date the newly eligible dependent first becomes eligible. The Effective Date will be that stated in the Eligibility Schedule for a Newly eligible Dependent (other than newborn, newly adopted child, stepchild, newly eligible grandchild or child subject to a MCSO/QMSO or child for whom guardianship has been granted by court or testamentary appointment).

2.7 Special Enrollment Periods. Special enrollment is allowed for certain individuals who lose coverage. Special enrollment is also allowed with respect to certain Dependent beneficiaries. If only the Subscriber is eligible under this Evidence of Coverage and Dependents are not eligible to enroll, as stated in the attached Eligibility Schedule, special enrollment periods for a Spouse/Dependent child are not applicable.

A. Special enrollment for certain individuals who lose coverage:

1. CareFirst will permit certain 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 an 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:

i. The employee and the Dependents are otherwise eligible to enroll;

ii. When coverage was previously offered, the employee had coverage under a group health plan or health insurance coverage; and

iii. The employee satisfies the conditions of Section 2.7A.2.c. i., ii., or iii. of this section, and if applicable, Section 2.7A.2.c. iv. of this section.

b. When a Dependent loses coverage.

i. 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 a group health plan or health insurance coverage; and

3) The Dependent satisfies the conditions of Section 2.7A.2.c. i., ii., or iii., of this section, and if applicable, Section 2.7A.2.c.iv. of this section.

ii. However, CareFirst is not required to enroll any other Dependent unless the Dependent satisfies the criteria of this Section 2.7A. 2.b., or the employee satisfies the criteria of Section 2.7A.2.a. of this section.

c. Conditions for special enrollment.

i. Loss of eligibility for coverage. In the case of an employee or Dependent who has coverage that is not COBRA continuation coverage, the conditions of this Section 2.7A.2.c.i are satisfied at the time the coverage is terminated as a result of loss of eligibility (regardless of whether the individual is eligible for or elects COBRA continuation coverage). Loss of eligibility under this Section 2.7A.2.c.i 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 by the employee or Dependent (such as making a fraudulent claim or an intentional misrepresentation of a material fact). Loss of eligibility for coverage under this Section 2.7A.2.c.i 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. If the Subscriber is enrolling because his or her Spouse was involuntarily terminated from employment (other than for cause) or because of the death of his or her Spouse, the Subscriber has up to six (6) months after the termination of the Spouse's coverage to submit an enrollment form;

2) In the case of coverage offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an

individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual);

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

4) A situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits, at which time the individual must be allowed thirty-one (31) days after the claim is denied to apply for coverage; and

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

ii. Termination of employer contributions. In the case of an employee or Dependent who has coverage that is not COBRA continuation coverage, the conditions of this Section 2.7A.2.c are satisfied at the time employer contributions towards the employee's or Dependent's coverage terminate. Employer contributions include contributions by any current or former employer that was contributing to coverage for the employee or Dependent.

iii. Exhaustion of COBRA continuation coverage. In the case of an employee or Dependent who has coverage that is COBRA continuation coverage, the conditions of this Section 2.7A.2.c are satisfied at the time the COBRA continuation coverage is exhausted. For purposes of this Section 2.7A.2.c.iii, an individual who satisfies the conditions for special enrollment of Section 2.7A.2.c.i. of this section, does not enroll, and instead elects and exhausts COBRA continuation coverage satisfies the conditions of this Section 2.7A.2.c.iii.

iv. Written statement. The Group or CareFirst may require an employee declining coverage (for the employee or any Dependent of the employee) to state in writing whether the coverage is being declined due to other health coverage only if, at or before the time the employee declines coverage, the employee is provided with notice of the requirement to provide the statement (and the consequences of the employee's failure to provide the statement). If the Group or CareFirst requires such a statement, and an employee does not provide it, the Group and CareFirst are not required to provide special enrollment to the employee or any Dependent of the employee under this Section 2.7A. The Group and CareFirst must treat an employee as having satisfied the requirement permitted under this Section 2.7A.2.c.iv 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.)

d. Effective Date. If the Subscriber enrolls within thirty-one (31) days of the date he or she becomes eligible to enroll, as described in this Section 2.7A, the Effective Date of coverage will be the first of the month following the date the completed request was received by CareFirst.

B. Special enrollment with respect to certain Dependent beneficiaries:

1. Provided the Group provides coverage for Dependents, CareFirst will permit the individuals described in Section 2.7B.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 Section 2.7B.2 if he or she is otherwise eligible for coverage in a benefit package under the Group's plan and if he or she is described in Section 2.7B.2.a-f. of this section.

a. Current employee only. A current employee is described in this Section 2.7B.2.a if a person becomes a Dependent of the individual through marriage, birth, Adoption, or placement for Adoption.

b. Spouse of an employee only. An individual is described in this Section 2.7B.2.b if either:

i. The individual becomes the Spouse of a employee; or

ii. The individual is a Spouse of an employee and a Child becomes a Dependent of the employee 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 Section 2.7B.2.c if either:

i. The employee and the Spouse become married; or

ii. 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 an employee only. An individual is described in this Section 2.7B.2.d if the individual is a Dependent of an employee and the individual has become a Dependent of the employee 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 Section 2.7B.2.e 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 Section 2.7B.2.f if the Dependent becomes a Dependent of the employee through marriage, birth, Adoption, or placement for Adoption.

3. If an individual is eligible for coverage as a Subscriber under this contract but is not enrolled, and an individual becomes his or her Dependent through marriage, and if the Subscriber enrolls within thirty-one (31) days of the marriage, the Effective Date of coverage for the Subscriber and any eligible Dependents will be the first of the month following the date the completed request was received by CareFirst.

4. If an individual is eligible for coverage as a Subscriber under this contract but is not enrolled, and an individual becomes his or her Dependent Child, and if the Subscriber enrolls within thirty-one (31) days of the date of birth, the date of Adoption or placement for Adoption, the Effective Date of coverage is the date of birth, the date of Adoption or placement for Adoption whichever occurs first.

5. The Effective Date of coverage for an enrolled Subscriber's new Dependent acquired through marriage will be that stated in the Eligibility Schedule for a Newly eligible Dependent (other than newborn, newly adopted child, stepchild, newly eligible grandchild or child subject to a MCSO/QMSO or child for whom guardianship has been granted by court or testamentary appointment). The Effective Date of coverage for an enrolled Subscriber's new Dependents acquired through birth, adoption, or placement for adoption will be that stated in the Eligibility Schedule for a Newborn, Newly Adopted Child, Stepchild, Newly Eligible Grandchild or Child Subject to a MCSO/QMSO or Child for whom Guardianship Has Been Granted by Court or Testamentary Appointment.

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

1. CareFirst will permit a Subscriber 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:

   a. The Subscriber 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 Subscriber or Dependent under such a plan is terminated as a result of loss of eligibility for such coverage;

   b. The Subscriber or Dependent becomes eligible for premium assistance, with respect to coverage under a group health plan or health insurance 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).

2. Notification Requirement.

   a. The Subscriber must notify the Group, and the Group must notify CareFirst no later than sixty (60) days after the date the Subscriber's or Dependent's coverage 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.

   b. The Subscriber must notify the Group, and the Group must notify CareFirst, no later than sixty (60) days after the date the Subscriber or Dependent is determined to be eligible for premium assistance, with respect to coverage under a group health plan or health insurance 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).

3. Effective Date of Coverage. If the Subscriber or Dependent is eligible to enroll for coverage under this Group Contract pursuant to this special enrollment and the notification requirement has been met then such coverage will be effective on:

   a. the date the Subscriber's or Dependent's coverage 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,

   b. the date the Subscriber or Dependent is determined to be eligible for premium assistance with respect to coverage under this Group Contract.

2.8 Effective Dates. Coverage will be effective as stated in the Eligibility Schedule.

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

2.10 Cooperation and Submission of Information. CareFirst may require verification from the Group and/or Subscriber pertaining to the eligibility of a Subscriber or Dependent enrolled hereunder. The Group and/or Subscriber agree to cooperate with and assist CareFirst, including providing CareFirst with reasonable access to Group records upon request.

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

SECTION 3
TERMINATION OF COVERAGE

3.1 Cancellation of Individual Members. Except as provided under the continuation of benefits provisions described in this Evidence of Coverage, coverage of individual Members will terminate as described in this section. Except for the events described in paragraphs C, D and G of this section, a Subscriber or Dependent may not terminate coverage or otherwise reduce coverage during a contract year.

A. The Group is required to terminate a Subscriber's coverage and the coverage of all Dependents if the Subscriber:

1. Is no longer employed by the Group; or

2. No longer meets the Group's eligibility requirements for coverage.

The Group is required to notify the Subscriber if coverage is canceled. If the Group does not notify the Subscriber, this will not continue coverage beyond the effective date of the cancellation of the Subscriber's coverage.

B. CareFirst may terminate the Member's coverage with 31 days prior written notice if CareFirst determines that:

1. The Subscriber furnished CareFirst with incorrect or incomplete information, which is material to the acceptance of the Enrollment Form. (This provision is limited to the 24-month period following the Subscriber's effective date of coverage under this Group Contract.) As a Member, all information contained in the Enrollment Form is true, correct and complete to the best of the Member's knowledge and belief.

2. The Member allowed another person to use his or her identification card or that the Member used another person's card. The card must be returned to CareFirst upon request.

3. The Member made fraudulent misstatements related to coverage or benefits under this Group Contract.

4. Nonpayment of charges when due, including premium contribution that may be required by the Group. Coverage ends on the date stated in CareFirst's written notice of termination (after the expiration of any grace period for nonpayment of premiums).

C. If certain life events occur, a Subscriber may be able to make a mid-year change to reduce and/or terminate the coverage of the Subscriber or Dependent. The following is a list of qualifying life events that allow the Subscriber to reduce or terminate coverage. The changes in coverage must satisfy the consistency requirements as described below.

1. Qualifying Life Events

a. Legal marital status. A change in a Subscriber's legal marital status, including marriage, divorce, death of Spouse, a legal separation or an annulment.

b. Domestic Partnership status. At the Group administrator's discretion, a change in status of a Subscriber's Domestic Partnership status, including establishment or termination of a Domestic Partnership or death of the Subscriber's Domestic Partner.

c. Employment status. A change in a Subscriber's, Spouse's or Dependent's employment status due to termination or commencement of employment, a strike or lockout, an unpaid leave of absence, or a change in worksite.

d. Dependent status. A change in status of a Dependent that results in the Dependent's eligibility or ineligibility for coverage because of age or similar circumstances.

2. Any reduction or termination that a Subscriber makes must be consistent with the life event. The life event must affect eligibility for coverage under this Group Contract or under a plan of the Spouse or Dependent, which covers the Spouse or Dependent as a Subscriber. The change in coverage must correspond with the life event.

D. Under certain circumstances, a Subscriber may make mid-year reduction or termination to coverage for reasons, such as coverage, cost or Medicare eligibility as described below.

1. Coverage Events:

a. If there is reduction or elimination of coverage during the contract year.

b. If the Spouse's plan allows a Subscriber and Dependents to make an enrollment change during that plan's annual open enrollment period, the Subscriber may make a corresponding mid-year change.

2. Cost Events: If the cost of coverage increases or decreases significantly during a contract year (including a Subscriber's change from part-time to full-time work or vice versa) and the Group does not offer a similar, but less costly, coverage option.

3. Entitlement to Medicare. If a Subscriber, Spouse or Dependent becomes eligible for Medicare mid-year, a Subscriber, Spouse or Dependent ***may*** **(but is not required)** terminate coverage.

E. Except for termination under paragraphs C. and D. upon cancellation of the coverage of a Subscriber under this section, all benefits for the Subscriber and his or her Dependents under the Group Contract will end on the termination date stated in the attached Eligibility Schedule, except in the case of a Member who is entitled to continued coverage under this section or under the Extended Benefits section of this Evidence of Coverage, in which case benefits will end on the date stated in the applicable section. If the Subscriber or Dependent terminates for reasons described in Paragraph C. or D. the effective date of termination shall be 11:59 p.m. on the last day of the month in which the Subscriber or Dependent requested the termination of coverage.

F. It is the Subscriber's responsibility to notify CareFirst (through the Group) of any changes in the status of his or her Dependents, which affect their eligibility for coverage under this Group Contract. If the Subscriber does not notify CareFirst of any changes and it is later determined that a Dependent was not eligible for coverage, CareFirst has the right to recover the full value of the services and benefits provided during the period of ineligibility. CareFirst can recover these amounts from the Subscriber or from the Dependent, at CareFirst's option.

G. In the event of the Subscriber's death, coverage of any Dependents will continue under the Subscriber's enrollment until the date stated in the Eligibility Schedule under this section. Thereafter, the Dependents may be eligible for continuation of coverage described in this Evidence of Coverage.

3.2 Medical Child Support Orders or Qualified Medical Support Orders. Unless coverage is terminated for non-payment of the premium, a child subject to a 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;

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

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

3.3 Continuation of Eligibility upon Loss of Group Coverage.

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

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

If 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. If a Member has any questions regarding USERRA, the Member should contact the plan administrator. The plan administrator determines eligible employees and provides that information to CareFirst.

C. Maryland Continuation. When Maryland Continuation applies, the Member may continue coverage under the Evidence of Coverage as follows:

1. Continuation for Spouse and Children after the Subscriber's Death. This provision applies in the event of the death of a Subscriber who was a resident of Maryland, was covered under the Group Contract or predecessor Group Contract with the same employer for at least three (3) months and whose coverage included one (1) or more Dependents at the time of death. This provision also applies to a newborn child of the deceased Subscriber born to the surviving Spouse after the Subscriber's death. When this provision applies, Dependents of the Subscriber may elect to remain covered under the Group Contract until the earliest of any of the following:

a. Eighteen (18) months after the date of the Subscriber's death;

b. The date on which the Dependent fails to make timely payment for this continuation coverage;

c. The date on which the Dependent is enrolled in other Group or non-Group coverage;

d. The date on which the Dependent becomes entitled to benefits under Medicare;

e. The date on which the Dependent elects to terminate coverage under the Group Contract;

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

g. The date on which the Group ceases to provide benefits to its employees under the Group Contract.

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

2. Continuation for Spouse and Children in the Event of Divorce. This provision applies in the event of the divorce of a Subscriber who is a resident of Maryland and whose coverage included one (1) or more Dependents at the time of divorce. This provision also applies to a newborn child of the Subscriber born to the former Spouse after the date of divorce.

a. When this provision applies, Dependents of the Subscriber may continue to be covered under the Group Contract until the earliest of any of the following:

i. The date on which the Subscriber's coverage under the Group Contract is terminated;

ii. The date on which the Subscriber or Dependent fails to make timely payment for this continuation coverage;

iii. The date on which the Dependent is enrolled in other Group or non-Group coverage;

iv. The date on which the Dependent becomes entitled to benefits under Medicare;

v. With regard to the coverage of a Spouse, the last day of the month in which the Spouse remarries;

vi. With regard to the coverage of a covered child, the date on which the covered child would no longer have been covered under the Group Contract if the Subscriber's divorce had not occurred, for example if the child attains the Limiting Age;

vii. The effective date of an election by the Dependent to no longer be covered under the Group Contract; or

viii. The date on which the Group ceases to provide benefits to its employees under the Group Contract.

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

i. Sixty (60) days following the divorce if, on the date of the divorce, the Subscriber is covered under the Group Contract or another Group health plan offered by the Group; or

ii. Thirty (30) days following the Effective Date of the Subscriber's coverage under this Evidence of Coverage if, on the date of the divorce, the Subscriber was covered under a Group health plan offered through a different employer.

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

3. State Continuation for Subscriber and Dependents in the Event of Voluntary or Involuntary Termination of Employment for Any Reason Other Than Cause. This provision applies in the event of the voluntary and involuntary termination of employment of a Subscriber who is a resident of Maryland, who was terminated from employment for any reason other than cause and who was covered under the Group Contract or predecessor Group Contract with the same employer for at least three (3) months prior to the termination of employment.

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

i. Eighteen (18) months after the date of termination of the Subscriber's employment;

ii. The date on which the Subscriber or Dependent fails to make timely payment for this continuation coverage;

iii. The date on which the Subscriber or Dependent is enrolled in other Group or non-Group coverage;

iv. The date on which the Subscriber becomes entitled to benefits under Medicare;

v. The effective date of an election by the Subscriber to no longer be covered under the Group Contract;

vi. The date on which the employer ceases to provide benefits to its employees under a Group Contract;

vii. With regard to the coverage of a covered child, the date on which the covered child would no longer have been covered under the Group Contract if the Subscriber's employment had not terminated, for example if the child attains the Limiting Age.

b. This continuation coverage must be elected, through submission of a signed election notification form to the Group, within forty-five (45) days after termination of the Subscriber's employment. The Subscriber is responsible for payment through the Group of the full cost of this

continuation coverage that may include a reasonable administrative fee not to exceed two percent (2%) of the premium, which is payable to and retained by the Group. No evidence of insurability is required.

3.4 Conversion Privileges. This Group Contract carries no conversion privileges.

3.5 Extended Benefits.

A. CareFirst shall provide Covered Dental Services, in accordance with the Evidence of Coverage in effect at the time the Member's coverage terminates, for a course of treatment for at least ninety (90) days after the date coverage terminates if the treatment:

1. Begins before the date coverage terminates; and

2. Requires two or more visits on separate days to a Dentist's office.

During an extension period required under this section a premium may not be charged.

B. This provision does not apply if:

1. Coverage is terminated because an individual fails to pay a required premium;

2. Coverage is terminated for fraud or material misrepresentation by the individual; or

3. Any coverage provided by a succeeding health benefit plan:

a. Is provided at a cost to the individual that is less than or equal to the cost to the individual of the extended benefit required under this section; and

b. Does not result in an interruption of benefits.

3.6 Right to Continue Coverage. If a Member is eligible to continue coverage under the Group Contract according to state and federal continuation provisions, the Member is entitled to utilize both provisions. Any differences in qualifications or benefits between the federal and state provisions will be resolved in favor of the Member.

3.7 Effect of Termination. Except as provided in the Extension of Benefits section above, 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.

3.8 Reinstatement. Coverage will not reinstate automatically under any circumstances.

SECTION 4
COORDINATION OF BENEFITS ("COB"); SUBROGATION

4.1 Coordination of Benefits ("COB").

A. Applicability.

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

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

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

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

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

Allowable Expenses means any health care expense, including Deductibles, Coinsurance or Copayments that are covered in whole or in part by any of the Plans covering the Member. This means that any expense or portion of an expense that is not covered by any of the Plans is not an Allowable Expense.

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 under a governmental Plan, or coverage required or provided by law. This does not include a State Plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time.)

The term Plan does not include:

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

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

3. Coverage regulated by a motor vehicle reparation law;

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

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

6. Personal injury protection benefits under a motor vehicle liability insurance policy.

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

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

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

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

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

C. Order of Determination Rules.

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

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

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

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

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

      i. Secondary to the Plan covering the person as a dependent, and

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

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

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

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

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

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

ii. For a dependent child whose parents are separated, divorced, or are not living together:

(a) 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 that actual knowledge of the terms of the court decree.

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

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

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

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

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

The rule described in C.2.b.i 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.

iii. 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 i. and ii. of this paragraph as if those individuals where parents of the child.

iv. For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in section C.2.e. applies.

In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in sections C.2.b.i. and ii. to the dependent child's parent(s) and the dependent's spouse.

c. Active/inactive employee. The Plan that covers a person as an active employee that is, an employee who is neither laid off nor retired or as a dependent of an active employee is the Primary Plan. The Plan covering that same person as a laid off or retired employee or as a dependent of a retired or laid off employee is the Secondary Plan. 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. This rule does not apply if the rule in section C.2.a. can determine the order of benefits.

d. 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:

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

ii. 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.

This rule does not apply if the rule in section C.2.a. can determine the order of benefits.

e. Longer/shorter length of coverage.

i. If the preceding rules do not determine the order of benefits, the Plan that covered the person for the longer period of time is the Primary Plan and the Plan that covered the person for the shorter period of time is the Secondary Plan.

ii. To determine the length of time a person has been covered under a Plan, two successive Plans shall be treated as one if the covered person was eligible under the second Plan within twenty-four (24) hours after coverage under the first Plan ended.

iii. The start of a new Plan does not include:

(a) A change in the amount or scope of a Plan's benefits;

(b) A change in the entity that pays, provides or administers the Plan's benefits; or

(c) A change from one type of Plan to another, such as, from a single employer Plan to a multiple employer Plan.

iv. The person's length of time covered under a Plan is measured from the person's first date of coverage under that Plan. If that date is not readily available for a group Plan, the date the person first became a member of the group shall be used as the date from which to determine the length of time the person's coverage under the present Plan has been in force.

f. If none of the preceding rules determines the order of benefits, the allowable expenses shall be shared equally between the Plans.

D. Effect on the Benefits of this CareFirst Plan.

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

2. Reduction in this CareFirst Plan's benefits. 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 Allowable Expenses. 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.

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

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

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

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

2. Insurance companies, or,

3. Other organizations.

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

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

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

B. Medicare as Primary.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 5
GENERAL PROVISIONS

5.1 Claims and Payment of Claims.

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

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

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

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

3. Provide benefits directly to the non-insuring parent, the provider of the Covered Dental Services, or the appropriate child support enforcement agency of any State or the District of Columbia.

B. Proof of Loss. In order to receive benefits under this Evidence of Coverage, written proof of loss shall be furnished to CareFirst within the deadlines described below.

1. Claims for Covered Dental Services must be submitted within twelve (12) months following the dates services were rendered.

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

3. CareFirst will honor claims submitted for Covered Dental 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.

C. Time of Payment of Claims. Benefits payable under this policy will not be paid more than thirty (30) days after receipt of written proof of loss.

D. Claim Payments Made in Error. If CareFirst makes a claim payment to or on behalf of the 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 that owed CareFirst and CareFirst

makes a subsequent benefit payment, CareFirst may subtract the amount owed CareFirst from the subsequent payment.

E. Payment of Claims. Payments for Covered Dental Services rendered by Participating or Preferred Dentists will be paid directly to the Participating or Preferred Dentists or to their representatives.

If a Member makes an Assignment of Benefits for services rendered by a Non-Participating Dentist who is a physician, payment for services will be paid directly to the Non-Participating Dentist who is a physician, except as provided in Section 5.4.C. If a Member receives Covered Dental Services from any other Non-Participating Dentist other than a physician who accepts an Assignment of Benefits, CareFirst reserves the right to pay either the Member or the provider. Such payment shall constitute full and complete satisfaction of CareFirst's obligation.

When a child Dependent is covered under a court or administrative order or a Qualified Medical Support Order and the parent who is not the Subscriber incurs covered expenses on the child Dependent's behalf, CareFirst reserves the right to make payment for these covered expenses to the non-Subscriber parent, the provider or the Maryland Department of Health and Mental Hygiene. In any case, CareFirst's payment will be in full and complete satisfaction of CareFirst's obligation.

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

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

5.4 No Assignment. A Member cannot assign any benefits or payments due under this Evidence of Coverage to any person, corporation or other organization, except a Member may:

A. Make an Assignment of Benefits to a Non-Participating Dentist who is a physician; or

B. Assign any other benefits or payments under the Evidence of Coverage only as specifically provided by this Evidence of Coverage or required by law.

C. Notwithstanding any permitted and valid Assignment of Benefits, CareFirst may refuse to directly reimburse a Non-Participating Dentist who is a physician, who accepts an Assignment of Benefits if:

1. CareFirst receives notice of the Assignment of Benefits after the time that it has paid the benefits to the Member;

2. CareFirst, due to an inadvertent administrative error, has previously paid the Member;

3. The Member withdraws the Assignment of Benefits before CareFirst has paid the Non-Participating Dentist who is a physician; or

4. The Member paid the Non-Participating Dentist who is a physician the full amount due at the time of service.

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

5.6 Identification Card. Any card CareFirst issues to the Member, under this Evidence of Coverage, is for identification only.

A. Possession of an identification card confers no right to benefits under this Evidence of Coverage.

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

C. Any person receiving benefits to which that person is not then entitled under the provisions of this Evidence of Coverage will be liable for the actual cost of such benefits.

5.7 Member Medical Records. It may be necessary to review and/or obtain medical records and information from hospitals, skilled nursing facilities, physicians or other practitioners who treat the Member. When a Member becomes covered under this Evidence of Coverage, the Member (or, if the Member is legally incapable of giving such consent, the representative of such Member) automatically gives CareFirst permission to obtain and use such records and information, including without limitation medical records and information requested to assist CareFirst in determining benefits and eligibility of Members.

5.8 Member Privacy. 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 Group or unauthorized third parties any personally identifiable medical information without the prior written authorization of the patient or parent/guardian or as otherwise permitted by law.

5.9 CareFirst's Relationship to Providers. Providers, including Participating or Preferred Dentists and Non-Participating Dentists, are independent individuals or organizations and are not employees or agents of CareFirst and are not authorized to act on behalf of or obligate CareFirst with regard to interpretation of the terms of this Evidence of Coverage, including eligibility of Members for coverage or entitlement to benefits. Participating or Preferred Dentists and Non-Participating Dentists maintain a provider-patient relationship with the Member and are solely responsible for the professional services they provide. CareFirst is not responsible for any acts or omissions, including those involving malpractice or wrongful death, of Participating or Preferred Dentists and Non-Participating Dentists or any other individual, facility or institution which provides services to Members or any employee, agent or representative of such providers.

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

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

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

benefits and rights to coverage under the Group health plan. Such rights include the right to continue coverage upon the occurrence of certain "Qualifying Events."

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

5.13 Rights to Vest in Guarantor. In the event of insolvency, CareFirst's rights under the Group Contract (including, but not limited to, all rights to premiums to the extent permitted by applicable bankruptcy law) will become vested in any person or entity that guarantees payment and actually pays for the services and benefits that CareFirst is obligated to make available under the Group Contract.

5.14 Rules for Determining Dates and Times. The following rules will be used when determining dates and times under the Group Contract:

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

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

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

D. Day means a calendar day, including weekends, holidays, etc., unless a different basis is specifically stated.

E. Year means a calendar year, unless a different basis is specifically stated.

5.15 Notices. Whenever the terms of the Group Contract or Evidence of Coverage require the Member, CareFirst or the Group to "give notice" or "notify" another party, the following requirements apply:

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

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

CareFirst of Maryland, Inc.
10455 Mill Run Circle
Owings Mills, Maryland 21117-5559

Notice will be effective on the date of receipt by CareFirst, unless the notice is sent by registered mail, in which case the notice is effective on the date of mailing, as certified by the Postal Service. CareFirst may change the address at which notice is to be given by giving written notice to the Group.

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

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

5.18 Complaints about CareFirst. Members may complain to the Maryland Insurance Administration about the operation of CareFirst. Such complaints would include matters other than coverage decisions or adverse decisions as described in the benefit determinations and appeals procedures attached to this Evidence of Coverage. To complain about the operation of CareFirst, Members should contact:

Maryland Insurance Administration
Life and Health Complaints
200 St. Paul Place, Suite 2700
Baltimore, Maryland 21202
Tel: 410-468-2244
Toll Free: 1-800-492-6116
Fax: 410-468-2260
Website: http://www.mdinsurance.state.md.us

5.19. Contestability of Coverage. This Group Contract may not be contested, except for nonpayment of premiums, after it has been in force for two (2) years from its date of issue. Any rescission of coverage of the Group or of any Member shall only be based upon an act, practice or omission that constitutes fraud or is due to an intentional misrepresentation of material fact. Absent fraud, each statement made by an applicant, Group, or Member is considered to be a representation and not a warranty. A statement made to effectuate coverage may not be used to avoid the coverage or reduce benefits under this Group Contract unless the statement is contained in a written instrument signed by the Group or Member, and a copy of the statement is given to the Group or Member. CareFirst shall give thirty (30) days advance written notice of any rescission of coverage of the Group or any Member. This provision does not preclude the assertion at any time of defenses to any claim based upon the person's ineligibility for coverage under this Group Contract or upon other provisions in this Group Contract.

CareFirst of Maryland, Inc.

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

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

An independent licensee of the BlueCross and BlueShield Association

ATTACHMENT A

BENEFIT DETERMINATION AND APPEAL AND GRIEVANCE PROCEDURES

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

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

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

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A. DEFINITIONS

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

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

Adverse Decision means a utilization review determination that:

1. A proposed or delivered health care service covered under the Member's contract is or was not Medically Necessary, appropriate, or efficient; and

2. May result in non-coverage of the health care service. Adverse Decision does not include a Coverage Decision.

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

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

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

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

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

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

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

Coverage Decision means:

1. An initial determination by the Plan or the Plan's Designee that results in non-coverage of a health care service;

2. An determination by the Plan that that an individual is not eligible for coverage under the Evidence of Coverage; or

3. A determination by the Plan that results in the Rescission of an individual's coverage under the Evidence of Coverage;

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

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

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

Filing Date means the earlier of:

1. 5 days after the date of mailing; or

2. The date of receipt.

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

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

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

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

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

1. An individual who is licensed under the Health Occupations Article, Annotated Code of Maryland, to provide health care services in the ordinary course of business or practice of a profession and is a treating provider of the Member; or

2. A hospital as defined in Title 19 Subtitle 3 of the Health-General Article.

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

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

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

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

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

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

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

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

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

1. Was relied upon in making the benefit determination;

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

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

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

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

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

1. A medical condition, including a physical condition, a mental condition, or a dental condition, where the absence of medical attention within 72 hours could reasonably be expected by an individual, acting on behalf of the Plan, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, to result in:

    a. Placing the member's life or health in serious jeopardy;

    b. The inability of the member to regain maximum function;

    c. Serious impairment to bodily function;

    d. Serious dysfunction of any bodily organ or part; or
    e. The member remaining seriously mentally ill with symptoms that cause the member to be a danger to self or others; or

2. A medical condition, including a physical condition, a mental health condition, or a dental condition, where the absence of medical attention within 72 hours in the opinion of a Health Care Provider with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the coverage decision.

B. SCOPE

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

C. CLAIMS PROCEDURES

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

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

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

D. CLAIMS PROCEDURES COMPLIANCE

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

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

   a. Is a communication by a Member, the Member's Representative, or Health Care Provider acting on behalf of the Member that is received by the person or organizational unit designated by the Plan or Plan Designee that handles Claims for Benefits; and

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

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

E. TIMING OF NOTIFICATION OF ADVERSE BENEFIT DETERMINATIONS

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

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

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

      i. Receipt of the specified information, or

      ii. The end of the period afforded the Member to provide the specified additional information.

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

      i. Any reduction or termination of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments shall constitute an Adverse Benefit Determination. The Member shall be notified in accordance with paragraph E.2.e herein, of the Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow the Member to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated.

      ii. Any request by a Member to extend the course of treatment beyond the period of time or number of treatments that is a Claim Involving Urgent Care shall be decided as soon as possible, taking into account the medical exigencies. The Member shall be notified of the benefit determination, whether adverse or not, within 24 hours after receipt of

the claim, provided that any such claim is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Notification of any Adverse Benefit Determination concerning a request to extend the course of treatment, whether involving urgent care or not, shall be made in accordance with paragraph F. herein, and an Appeal shall be governed by paragraphs G.2, G.3 and G.4 herein as appropriate.

iii. If a health care service for a Member has been preauthorized or approved by the Plan or the Plan's Designee, the Plan may not deny reimbursement to the Health Care Provider for the preauthorized or approved service delivered to the Member unless:

1) The information submitted regarding the service was fraudulent or intentionally misrepresentative;

2) Critical information required by the Plan or the Plan's Designee was omitted such that the Plan or Plan Designee's determination would have been different had it known the critical information;

3) A planned course of treatment for the Member was not substantially followed by the Health Care Provider; or

4) On the date the preauthorized service was delivered:

a) the Member was not covered by the Plan;

b) the Plan or the Plan's Designee maintained an automated eligibility verification system that was available to the Provider by telephone or via the Internet; and

c) according to the verification system, the Claimant was not covered by the Plan.

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

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

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

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

ii. Post-Service Claims. In the case of a Post-Service Claim, the Member shall be notified, in accordance with paragraph G. herein, of the Adverse Benefit Determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time for up to 15 days, provided that the Plan or the Plan's Designee both determines that such an extension is necessary and notifies the Member, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered. If such an extension is necessary, the Plan or the Plan's Designee will send a Notice of receipt and status of the claim that states the legitimacy of the claim or the appropriate amount of reimbursement is in dispute and additional information is necessary to determine if all or part of the claim will be reimbursed and what specific additional information is necessary; or that the claim is not clean and the specific additional information necessary for the claim to be considered a clean claim. The Member shall be afforded at least 45 days from receipt of the Notice within which to provide the specified information.

d. Rescission determinations. The Plan shall provide 30-days advance written Notice of any proposed Rescission of coverage for any individual.

e. Calculating time periods. For purposes of paragraph E. herein the period of time within which a benefit determination is required to be made shall begin at the time a claim is filed, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended as permitted pursuant to paragraph E.2 above due to a Member's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the Notification of the extension is sent to the Member until the date on which the Member responds to the request for additional information.

F. MANNER AND CONTENT OF NOTIFICATION OF ADVERSE BENEFIT DETERMINATIONS

1. This section sets forth the manner and content of Notifications by the Plan of Adverse Benefit Determinations.

2. In the case of an Adverse Decision, the Plan or the Plan's Designee shall send a Member, the Member's Representative or Health Care Provider acting on behalf of the Member written or electronic Notification of any Adverse Benefit Determination. In the case of an Adverse Decision relating a Claim for Benefits that is not a Claim Involving Urgent Care, the Plan or the Plan's Designee shall send the written or electronic Notification within 5 working days after the Adverse Decision has been made. The Notification shall set forth, in a manner calculated to be understood by the Member, the Member's Representative or Health Care Provider:

   a. The identity of the claim involved (including the date of service, the Health Care Provider and the claim amount (if applicable)).

   b. The specific reason or reasons for the Adverse Decision;

c. Reference to the specific Plan provisions on which the Adverse Decision is based;

d. A description of any additional material or information necessary for the Member, the Member's Representative or Health Care Provider acting on behalf of the Member to perfect the claim and an explanation of why such material or information is necessary;

e. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Member's right to bring a civil action under Section 502(a) of the Act following an Adverse Decision;

f. The Medical Director's name, business address and business telephone number;

g. If an internal rule, guideline, protocol, diagnosis code, treatment code, or other similar criterion was relied upon in making the Adverse Decision , either (i) the specific rule, guideline, protocol, diagnosis code (and its corresponding meaning), treatment code (and its corresponding meaning) or other similar criterion; or (ii) a statement that such a rule, guideline, protocol, diagnosis code, treatment code, or other similar criterion was relied upon in making the Adverse Decision and that a copy of such rule, guideline, protocol, diagnosis code (and its corresponding meaning) or treatment code (and its corresponding meaning), or other criterion will be provided free of charge to the Member upon request; or

h. If the Adverse Decision is based on a Medical Necessity or Experimental/Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Member's medical circumstances.

i. In the case of an Adverse Decision by the Plan or the Plan's Designee concerning a Claim Involving Urgent Care, a description of the expedited review process applicable to such claims. This information may be provided orally to the Member, the Member's Representative or Health Care Provider acting on behalf of the Member within the timeframe prescribed in paragraph E.2. herein. The Member, the Member's Representative or Health Care Provider acting on behalf of the Member must be provided a written or electronic Notification no later than one (1) day after the oral Notification.

j. That the Member, the Member's Representative or Health Care Provider acting on behalf of the Member has a right to file a Complaint with the Commissioner within 4 months after receipt of the Plan's Grievance Decision;

k. That a Complaint may be filed without first filing a Grievance if

   i. The Plan notifies the Member in writing that it has waived the requirement that its internal grievance process be exhausted before filing a Complaint with the Commissioner;

   ii. The Plan has failed to comply with any of the requirements of the internal grievance procedure described in this attachment; or

   iii. the Member, the Member's Representative or Health Care Provider acting on behalf of the Member filing a Grievance on behalf of the Member can demonstrate a Compelling Reason to do so as determined by the Commissioner;

l. The Commissioner's address, telephone number, and facsimile number;

m. A statement that the Health Advocacy Unit is available to assist the Member, the Member's Representative or Health Care Provider acting on behalf of the Member in both mediating and filing a Grievance; and

n. The Health Advocacy Unit's address, telephone number, facsimile number, and electronic mail address.

3. In the case of a Coverage Decision, the Plan or the Plan Designee must within 30 calendar days provide Member, Member's Representative and the treating Health Care Provider, a written Notice of the Coverage Decision. The statement must state in detail, in clear, understandable language, the specific factual basis for the Plan's decision and must include the following information:

a. Where applicable, the identity of the claim involved (including the date of service, the Health Care Provider and the claim amount).

b. The specific reason or reasons for the Coverage Decision;

c. Reference to the specific Plan provisions on which the Coverage Decision is based;

d. A description of any additional material or information necessary for the Member, the Member's Representative or Health Care Provider acting on behalf of the Member to perfect the claim and an explanation of why such material or information is necessary;

e. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Member's right to bring a civil action under Section 502(a) of the Act following a Coverage Decision;

f. That the Member, Member's Representative or Health Care Provider acting on behalf of the Member has a right to file an Appeal with the Plan or the Plan's Designee;

g. In the case of a Coverage Decision by the Plan or the Plan's Designee concerning a Claim Involving Urgent Care, a description of the expedited review process applicable to such claims. This information may be provided orally to the Member, the Member's Representative or Health Care Provider acting on behalf of the Member within the timeframe prescribed in paragraph E.2. herein. The Member, the Member's Representative or Health Care Provider acting on behalf of the Member must be provided a written or electronic Notification no later than one (1) day after the oral Notification.

h. That the Member, the Member's Representative or Health Care Provider acting on behalf of the Member has a right to file a Complaint with the Commissioner within 4 months after receipt of the Plan's Appeal Decision;

i. That the Member, Member's Representative or Health Care Provider acting on behalf of the Member may file a Complaint with the Commissioner without first filing an Appeal, if the Coverage Decision involves a Claim Involving Urgent Care which has not been rendered;

j. The Commissioner's address, telephone number, and facsimile number;

k. A statement that the Health Advocacy Unit is available to assist the Member, the Member's Representative or Health Care Provider acting on behalf of the Member in both mediating and filing an Appeal; and

l. The Health Advocacy Unit's address, telephone number, facsimile number, and electronic mail address.

4. Adverse Benefit Determinations are made under the direction of the Medical Director.

G. APPEALS AND GRIEVANCES OF ADVERSE BENEFIT DETERMINATIONS

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

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

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

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

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

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

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

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

b. In deciding a Grievance of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental/Investigational, or not Medically Necessary or appropriate, the Plan or the Plan's Designee shall consult with a Health Care Provider with the same specialty as the treatment under review.

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

d. Health Care Provider engaged for purposes of a consultation under paragraph H.3.b herein shall be individuals who were neither consulted in connection with

the Adverse Benefit Determination that is the subject of the Appeal or Grievance, nor subordinates of any such individuals; and

e. In the case of a Claim Involving Urgent Care, a request for an expedited Appeal or Grievance of an Adverse Benefit Determination may be submitted orally or in writing by the Member, the Member's Representative or Health Care Provider acting on behalf of the Member; and the Plan or the Plan's Designee must notify the Member, the Member's Representative or Health Care Provider acting on behalf of the Member of its determination in writing within 24 hours of receipt of the expedited request for Appeal or Grievance.

4. Full and fair review. The Plan or the Plan's Designee shall allow a Member, the Member's Representative or Health Care Provider acting on behalf of the Member to review the claim file and to present evidence and written testimony as part of the internal claims and Appeals or Grievances process. Specifically, in addition to the requirements of paragraphs G.2.a through c herein, the following apply:

a. The Plan or the Plan's Designee shall provide the Member, the Member's Representative or Health Care Provider acting on behalf of the Member, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan or the Plan's Designee (or at the direction of the Plan or the Plan's Designee) in connection with the claim; such evidence will be provided as soon as possible and sufficiently in advance of the date on which the Grievance Decision or Appeal decision is required to be provided under paragraph H. herein, to give the Member a reasonable opportunity to respond prior to that date; and

b. Before the Plan or the Plan's Designee issues a Grievance Decision or an Appeal Decision based on a new or additional rationale, the Member, the Member's Representative or Health Care Provider acting on behalf of the Member shall be provided, free of charge, with the rationale; the rationale shall be provided as soon as possible and sufficiently in advance of the date on which the Notice of Appeal Decision or Grievance Decision is required to be provided under paragraphs H and I. herein, to give the Member, the Member's Representative or Health Care Provider acting on behalf of the Member a reasonable opportunity to respond prior to that date.

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

1. The Plan or the Plan's Designee shall notify a Member, the Member's Representative or Health Care Provider acting on behalf of the Member of its benefit determination on review of an Adverse Decision in accordance with the following, as appropriate.

a. Urgent care claims. In the case of a Claim Involving Urgent Care, the Member, the Member's Representative or Health Care Provider acting on behalf of the Member shall be notified, in accordance with paragraph J. herein, of the Grievance Decision as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the Member's request for review of an Adverse Decision. A written Notification must be provided to the Member, the Member's Representative or Health Care Provider acting on behalf of the Member within 24 hours of the orally communicated Grievance Decision.

b. Pre-service claims. In the case of a Pre-Service Claim, the Member, the Member's Representative or Health Care Provider acting on behalf of the Member shall be notified, in accordance with paragraph J herein, of the Grievance Decision within a reasonable period of time appropriate to the medical circumstances. Oral Notification shall be provided not later than 30 days after

the filing date of the Member, the Member's Representative's or Health Care Provider's request for review of an Adverse Decision. A written Notification must be provided to the Member, the Member's Representative or Health Care Provider acting on behalf of the Member within 5 working days of the Grievance Decision.

c. Post-service claims. In the case of a Post-Service Claim, the Member, the Member's Representative or Health Care Provider acting on behalf of the Member shall be notified, in accordance with item J herein, of the Grievance Decision within a reasonable period of time. Oral Notification shall be provided not later than 45 working days after the filing date of the Member's, the Member's Representative's or Health Care Provider's request for review of an Adverse Decision. A written Notification must be provided to the Member, the Member's Representative or Health Care Provider acting on behalf of the Member within 5 working days of the Grievance Decision.

2. If the Plan or the Plan's Designee does not have sufficient information to complete its Grievance Decision, the Plan or the Plan's Designee must notify the Member, the Member's Representative or Health Care Provider acting on behalf of the Member within five (5) working days after the Filing Date of the Grievance by the Member, the Member's Representative or Health Care Provider acting on behalf of the Member with the Plan or the Plan's Designee. The Plan or the Plan's Designee Notification shall:

   a. Notify the Member, the Member's Representative or Health Care Provider acting on behalf of the Member that it cannot proceed with reviewing the Grievance unless additional information is provided; and

   b. Assist the Member, the Member's Representative or Health Care Provider acting on behalf of the Member in gathering the necessary information without further delay.

3. The Plan or the Plan's Designee may extend the 30-day or 45-working day period required for making an Grievance Decision under paragraph H.1.b., c. with the written consent of the Member, the Member's Representative or Health Care Provider acting on behalf of the Member who filed the Grievance on behalf of the Member. With the written consent of the Member, the Member's Representative or Health Care Provider acting on behalf of the Member who filed the Grievance on behalf of the Member, the Plan or the Plan's Designee may extend the period for making a final decision for an additional period of not longer than 30 working days. The Plan's extension request must describe the special circumstances necessitating the extension and the date on which the benefit determination will be made.

4. Calculating time periods. For purposes of Section H. herein, the period of time within which a Grievance Decision shall be made begins at the time a Grievance is received by the Plan or the Plan's Designee, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as permitted pursuant to paragraph H.2 herein due to a Member's, the Member's Representative's or Health Care Provider 's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the Notification of the extension is sent to the Member, the Member's Representative or Health Care Provider acting on behalf of the Member until the date on which the Member, the Member's Representative or Health Care Provider acting on behalf of the Member responds to the request for additional information.

5. In the case of Grievance, upon request, the Plan or the Plan's Designee shall provide such access to, and copies of Relevant documents, records, and other information described in paragraphs G.2, G.3, and G.4 herein as is appropriate.

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

1. The Plan or the Plan's Designee shall notify a Member, the Member's Representative or Health Care Provider acting on behalf of the Member of its Appeal Decision no later than 60 working days after the filing date of the Member, the Member's Representative 's or Health Care Provider's Appeal. A written Notification must be provided to the Member, the Member's Representative or Health Care Provider acting on behalf of the Member within 30 days of the Appeal Decision.

2. The Plan or the Plan's Designee may extend the 60-working day period required for making an Appeal Decision under I.1 with the written consent of the Member, the Member's Representative or Health Care Provider acting on behalf of the Member who filed the Appeal on behalf of the Member. With the written consent of the Member, the Member's Representative or Health Care Provider acting on behalf of the Member who filed the Appeal on behalf of the Member, the Plan or the Plan's Designee may extend the period for making a final decision for an additional period of not longer than 30 working days. The Plan's extension request must describe the special circumstances necessitating the extension and the date on which the benefit determination will be made.

3. Calculating time periods. For purposes of Section I. herein, the 60-working day period within which a benefit determination on review shall be made, subject to any extension granted pursuant to paragraph I.2 above, begins at the time an Appeal is received by the Plan or the Plan's Designee, without regard to whether all the information necessary to make an Appeal Decision accompanies the filing.

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

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

1. The identity of the claim involved (including the date of service, the Health Care Provider and the claim amount (if applicable)).

2. The specific factual basis for the adverse determination;

3. Reference to the specific criteria and standards, including interpretive guidelines, on which the benefit determination is based;

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

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

    a. If an internal rule, guideline, protocol, diagnosis code, treatment code, or other similar criterion was relied upon in making the adverse determination, either (i) the specific rule, guideline, protocol, diagnosis code (and its corresponding meaning), treatment code (and its corresponding meaning) or other similar criterion; or (ii) a statement that such a rule, guideline, protocol, diagnosis code, treatment code, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, diagnosis code

(and its corresponding meaning) or treatment code (and its corresponding meaning), or other criterion will be provided free of charge to the Member upon request; or;

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

c. You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available it so contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

7. In the case of a Grievance involving an Adverse Decision, a statement that includes the following information:

a. The name, business address and business telephone number of the Medical Director who made the decision;

b. That the Member, the Member's Representative or Health Care Provider acting on behalf of the Member has a right to file a Complaint with the Commissioner within 4 months after receipt of the Grievance Decision;

c. The Commissioner's address, telephone number, and facsimile number;

d. A statement that the Health Advocacy Unit is available to assist the Member, the Member's Representative or Health Care Provider acting on behalf of the Member with filing a Complaint with the Commissioner;

e. The Health Advocacy Unit's address, telephone number, facsimile number and electronic mailing address;

f. The Employee Benefit Security Administration's telephone number and website address; and

g. A Notice that, when filing a Complaint with the Commissioner, the Member or a legally authorized designee of the Member will be required to authorize the release of any medical records of the Member that may be required to be reviewed for the purpose of reaching a decision on the Complaint.

8. In the case of an Appeal involving a Coverage Decision, a statement that includes the following information:

a. That the Member, the Member's Representative or Health Care Provider acting on behalf of the Member has a right to file a Complaint with the Commissioner within 4 months after receipt of the Appeal Decision; and

b. The Commissioner's address, telephone number, and facsimile number;

c. The Employee Benefit Security Administration's telephone number and website address; and

d. A statement that the Health Advocacy Unit is available to assist the Member, the Member's Representative or Health Care Provider acting on behalf of the Member with filing a Complaint with the Commissioner;

e. The Health Advocacy Unit's address, telephone number, facsimile number and electronic mailing address; and

f. A Notice that, when filing a Complaint with the Commissioner, the Member or a legally authorized designee of the Member will be required to authorize the release of any medical records of the Member that may be required to be reviewed for the purpose of reaching a decision on the Complaint.

9. Grievance Decisions and Appeal Decisions are made under the direction of the Chief Medical Officer:

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

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

1. Within 4 months after the date of receipt of an Appeal Decision or a Grievance Decision, a Member, the Member's Representative or Health Care Provider acting on behalf of the Member may file a Complaint with the Commissioner for review of the Grievance Decision or Appeal Decision.

2. A Member, the Member's Representative or Health Care Provider acting on behalf of the Member may file a Complaint without first exhausting the Plan's internal Grievance or Appeals process if:

a. In the case of an Adverse Decision:

i. The Plan or the Plan's Designee waives the requirement that the internal Grievance process be exhausted before filing a Complaint with the Commissioner;

ii. The Plan or the Plan's Designee has failed to comply with any of the requirements of the internal Grievance process;

iii. The Member, the Member's Representative or Health Care Provider acting on behalf of the Member provides sufficient information and supporting documentation in the Complaint to demonstrate a Compelling Reason.

b. In the case of a Coverage Decision, the Complaint involves an Urgent Medical Condition for which care has not been rendered.

3. The remaining provisions of this paragraph K. apply to Complaints regarding Adverse Decisions and Grievance Decisions.

a. The Commissioner shall notify the Plan or the Plan's Designee of the Complaint within five working days after the date the Complaint is filed with the Commissioner.

b. Except for an Emergency Case (Claim Involving Urgent Care), the Plan or the Plan's Designee shall provide to the Commissioner any information requested by the Commissioner no later than seven working days from the date the Plan or the Plan's Designee receives the request for information.

4. a. Except as provided in paragraph K.4.b below, the Commissioner shall make a final decision on a Complaint:

i. Within 45 days after a Complaint is filed regarding a Pre-Service Claim;

ii. Within 45 days after a Complaint is filed regarding a Post-Service Claim; and

iii. Within 24 hours after a Complaint is filed regarding a Claim Involving Urgent Care.

b. The Commissioner may extend the period within which a final decision is to be made under paragraph.K.4.a. for up to an additional 30 working days if:

i. the Commissioner has not yet received information requested by the Commissioner; and

ii. the information requested is necessary for the Commissioner to render a final decision on the Complaint.

5. The Commissioner shall seek advice from an independent review organization or medical expert for Complaints filed with the Commissioner that involve a question of whether a Pre-Service Claim or a Post-Service Claim is Medically Necessary. The Commissioner shall select an independent review organization or medical expert to advise on the Complaint in the manner set forth in Section 15-10A-05 of the Insurance Article.

6. The Plan or the Plan's Designee shall have the burden of persuasion that its Adverse Decision or Grievance, as applicable, is correct during the review of a Complaint by the Commissioner or Designee of the Commissioner, and in any hearing held regarding the Complaint.

7. As part of the review of a Complaint, the Commissioner or Designee of the Commissioner may consider all of the facts of the case and any other evidence deemed Relevant.

8. Except as provided below, in responding to a Complaint, the Plan or the Plan's Designee may not rely on any basis not stated in its Adverse Benefit Determination.

a. The Commissioner may allow the Plan or the Plan's Designee, a Member, the Member's Representative or Health Care Provider acting on behalf of the Member to provide additional information as may be relevant for the Commissioner to make a final decision on the Complaint.

b. The Commissioner shall allow the Member, the Member's Representative or Health Care Provider acting on behalf of the Member at least 5 working days to provide the additional information.

c. The Commissioner's use of additional information may not delay the Commissioner's decision on the Complaint by more than five working days.

9. The Commissioner may request the Member or a legally authorized designee of the Member to sign a consent form authorizing the release of the Member's medical records to the Commissioner or Designee of the Commissioner that are needed in order for the Commissioner to make a final decision on the Complaint.

10. Subject to paragraphs H, a Member, the Member's Representative or Health Care Provider acting on behalf of the Member may file a Complaint with the Commissioner if the Member, the Member's Representative or Health Care Provider acting on behalf of the Member does not receive the Plan's Grievance Decision within the following timeframes:

a. Within 30 days after the filing date of a Grievance regarding a Pre-Service Claim;

b. Within 45 working days after the filing date of a Grievance regarding a Post-Service Claim; and

c. Within 24 hours after the receipt of a Grievance regarding a Claim Involving Urgent Care.

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

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

L. MEMBER COMMENTS AND QUALITY COMPLAINTS

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

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

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

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

M. DEEMED EXHAUSTION OF INTERNAL CLAIMS AND APPEAL PROCESS

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

N. MISCELLANOUS

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

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

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

CareFirst of Maryland, Inc.

Chester E. Burrell
President and Chief Executive Officer

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

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

An independent licensee of the Blue Cross and Blue Shield Association

ATTACHMENT B

DESCRIPTION OF COVERED SERVICES
BLUEDENTAL PLUS PROGRAM

The services described herein are eligible for coverage under the Evidence of Coverage. CareFirst will provide the benefits described in the Schedules of Benefits for Covered Dental 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 the Member will pay and any specific limits on the services that will be covered. The Schedule of Benefits also lists important information about other features that affect Member coverage, including Deductibles and Benefit Period Maximums.

Refer to the Evidence of Coverage for additional definitions of capitalized terms included in this Description of Covered Services.

CareFirst of Maryland, Inc.

Chester E. Burrell
President and Chief Executive Officer

SECTION 1 - AMOUNTS OF BENEFITS PAYABLE

1.1 Benefits for Covered Dental Services as stated in this Description of Covered Services will be provided by CareFirst in accordance with the coverage option elected by the Group and as specified in the attached Schedule of Benefits.

A. Benefits are payable under this Description of Covered Services for expenses incurred by the Member for Covered Dental Services only while the Member is covered under this Evidence of Coverage, except as stated in the Extended Benefits section of this Description of Covered Services.

B. The date a service is received or the date supplies are purchased will be the date such expenses are incurred.

1.2 Benefit Period.

A. A Benefit Period means the period of time during which Covered Dental Services are eligible for coverage as listed in the attached Schedule of Benefits.

B. As applied to the Member, a Benefit Period will be the period specified in the section above or that portion thereof during which the Member is covered under this Evidence of Coverage.

1.3 Deductible.

A. The Benefit Period Deductible described in the attached Schedule of Benefits, will be applicable to the Allowed Benefit for Covered Dental Services in the Classes specified.

B. Carry-Over Deductible. Covered Dental Services incurred in the last three (3) months of the Benefit Period which were applied to such Benefit Period's Deductible will be applied to the next Benefit Period's Deductible.

C. Deductible Credit. If a Member was covered on the day immediately preceding the Effective Date of this Evidence of Coverage under any other group agreement issued to the Group, then charges for Covered Dental Services (as defined) incurred by that Member and applicable toward the individual or family Deductible under the prior agreement, shall be used to satisfy all or any portion of the individual or family Deductible amounts under this Evidence of Coverage. This Deductible Credit provision applies only to the Deductible amount wholly or partially satisfied in the first Benefit Period in which the change in group health plans occurs.

1.4 Benefit Maximum.

A. Benefit Period Maximum. The total amount of benefits provided by CareFirst under this Evidence of Coverage will not exceed the maximum specified in the attached Schedule of Benefits with respect to each eligible Member in any Benefit Period. The Benefit Period Maximum will not include any Deductible or Coinsurance the Member pays to the Dentist. The in-network and out-of-network Benefit Period Maximum will be a combined amount. Once a Member reaches the Benefit Period Maximum, no further payments will be made by CareFirst for that Member for that Benefit Period. The Member shall be responsible for the Dentist's total charges associated with any dental treatment for which no dental benefit payment is due from CareFirst.

1.5 Coinsurance. When the Deductible has been met, the Member is responsible for the Member Coinsurance amount shown in the attached Schedule of Benefits for each Class. Coinsurance amounts are based on the Allowed Benefits for the services rendered.

1.6 Member/Provider Relationship.

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

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

1.7 Services of Participating Dentists.

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

B. CareFirst will pay benefits directly to the Dentist.

C. The Member is responsible for the Deductible and Coinsurance.

1.8 Services of Non-Participating Dentists.

A. Claims may be submitted directly to CareFirst by the Dentist, 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 as described in the Proofs of Loss section of this Description of Covered Services.

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

C. In the case of a Dependent Child enrolled pursuant to a court order, court approved requirement, Medical Child Support Order, or a Qualified Medical Child Support Order, payment may be paid directly to the appropriate child support enforcement agency of any State or the District of Columbia or the noninsuring parent.

D. The Member is responsible for the difference between CareFirst's payment and the Dentist's charge.

1.9 Services of Preferred Dentists.

Many Participating Dentists have special agreements with CareFirst and are part of a network of Preferred Dentists. In general, if a Member chooses a Preferred Dentist, the cost to the Member is lower than if the Member chooses a Non-Participating Dentist. In the attached Schedule of Benefits, the Coinsurance percentages are listed for services received from a Preferred Dentist.

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

1.10 Referral to a Non-Participating Dental Specialist. A Specialist is a Dentist who is certified or trained in a specified field of dentistry. A Member may request a referral to a Specialist who is a Non-Participating Dentist if:

A. The Member is diagnosed with a condition or disease that requires specialized dental care; and

1. CareFirst does not contract with a Specialist with the professional training and expertise to treat the condition or disease; or

2. CareFirst cannot provide reasonable access to a Specialist with the professional training and expertise to treat the condition or disease without unreasonable delay or travel.

For purposes of calculating any Deductible or Coinsurance payable by the Member, CareFirst will treat the services rendered by the Specialist as if the service was provided by a Preferred Specialist. The Member is responsible for the difference between the Allowed Benefit and the charge by a Non-Participating Specialist.

A decision by CareFirst not to provide access to or coverage of treatment by a Specialist with this section constitutes an Adverse Decision as defined in the Evidence of Coverage if the decision is based on a finding that the proposed service is not Medically Necessary, appropriate, or efficient.

1.11 Limitation on Provider Coverage. Services are covered only if the provider is licensed in the jurisdiction in which the services are rendered and if the services are within the lawful scope of the services for which that provider is licensed. Coverage does not include services rendered to a Member by any individual who is:

A. Not a health care practitioner.

B. Acting beyond the scope of practice.

C. Related to the Member, including but not limited to, self, parent, spouse, children, grandparent, grandchild, sibling, aunt, uncle, niece, nephew, or individual who resides in the Member's home.

D. Rendering services as a result of a referral that is prohibited by law.

1.12 Proofs of Loss. In order to receive benefits under this Description of Covered Services, written proof of loss shall be furnished to CareFirst within the deadlines described below.

A. Claims for Covered Dental Services must be submitted within twelve (12) months following the dates services were rendered.

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

C. CareFirst will honor claims submitted for Covered Dental 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 Description of Covered Services. 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.

1.13 Extended Benefits.

A. CareFirst shall provide covered benefits, in accordance with the Evidence of Coverage in effect at the time the Member's coverage terminates, for a course of treatment for at least 90 days after the date coverage terminates if the treatment:

1. Begins before the date coverage terminates; and

2. Requires two or more visits on separate days to a Dentist's office

During an extension period required under this section a premium may not be charged.

B. This provision does not apply if:

1. Coverage is terminated because an individual fails to pay a required premium;

2. Coverage is terminated for fraud or material misrepresentation by the individual; or

3. Any coverage provided by a succeeding health benefit plan:

a. Is provided at a cost to the individual that is less than or equal to the cost to the individual of the extended benefit required under this section; and

b. Does not result in an interruption of benefits.

1.14 Transitioning of Care from Member's Prior Carrier.

A. Prior Authorization. For Members transitioning care from the Member's immediate prior dental insurance carrier to CareFirst

1. At the request of the Member, the Member's parent, guardian or designee, or the Member's Dentist, CareFirst will accept a prior authorization from the Member's prior dental carrier for the dental services which are Covered Dental Services under this Evidence of Coverage; and,

2. For the following time period: the lesser of the course of treatment or ninety (90) days.

3. At the expiration of the time period stated in A.2 of this provision, CareFirst may elect to perform its own utilization review in order to:

a. reassess and make its own determination regarding the need for continued dental services; and

b. authorize any continued dental services or other Covered Dental Service determined to be Medically Necessary.

4. With respect to services provided through the Maryland Medical Assistance fee-for-service program, this provision will only apply to:

a. Member's transitioning care from the Maryland Medical Assistance Program to CareFirst; and,

b. Dental benefits to the extent that that they are authorized by a third-party administrator.

B. Continuing Treatment with a Non-Participating Dentist initiated while covered by the Member's immediate prior dental insurance carrier:

1. At the request of the Member, the Member's parent, guardian or designee, or the Member's Dentist, CareFirst will allow a Member to continue to receive Covered Dental Services rendered by a Non-Participating Dentist at the time of the Member's transition to coverage by CareFirst.

2. Continuing treatment with a Non-Participating Dentist pursuant to this provision is limited to:

a. acute conditions;

b. serious chronic conditions;

c. any other condition on which CareFirst and the Non-Participating Dentist reach an agreement on coverage.

3. The Member may continue care with the Non-Participating Dentist for the following time period: the lesser of the course of treatment or ninety (90) days.

4. For purposes of calculating any Deductible or Coinsurance payable by the Member, CareFirst will treat the services rendered by the Non-Participating Dentist as if the service was provided by a Preferred Dentist. The Member is not responsible for the difference between the Allowed Benefit paid to a Preferred Dentist and the charge by a Non-Participating Dentist if the Non-Participating Dentist accepts the Allowed Benefit paid to a Preferred Dentist as payment in full or the Non-Participating Dentist agrees to an alternative payment amount from CareFirst.

5. If the Non-Participating Dentist does not accept the Allowed Benefit paid to a Preferred Dentist and CareFirst cannot reach an agreement with the Non-Participating Dentist concerning payment for Covered Dental Services:

a. The Non-Participating Dentist is not required to continue to provide Covered Dental Services.

b. If the Non-Participating Dentist accepts the Member's Assignment of Benefits, the Non-Participating Dentist may Balance Bill the Member for the difference between the Allowed Benefit paid to a Preferred Dentist and the charge by a Non-Participating Dentist.

c. Unless the Member has executed an Assignment of Benefits to the Non-Participating Dentist, CareFirst will facilitate transfer of care of the Member to a Preferred Dentist.

SECTION 2 - COVERED DENTAL SERVICES

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

2.2 Class I - Preventive and Diagnostic Services

A. Services limited to twice per Benefit Period

1. Oral examination

2. Routine cleaning

3. Topical fluoride until the end of the year in which a Member reaches the age of 19

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

B. Services limited to twice per Benefit Period: bitewing x-rays not taken at the same time as those in C. below

C. Once per 36 months

1. One set of full mouth x-rays OR one panograph x-ray and one additional set of bitewing x-rays

2. One cephalometric x-ray

D. Services limited to once per tooth per 36 months: sealants on permanent molars until the end of the year in which a Member reaches the age of 19

E. Services limited to once per 60 months: space maintainers for prematurely lost cuspid to posterior deciduous teeth

F. Services as required

1. Palliative Treatments

2. Emergency Oral Exam

3. Periapical and occlusal x-rays

4. Professional consultation rendered by a Dentist, limited to one consultation per Dentist per condition

2.3 Class II - Basic Services

A. Direct placement fillings, including direct pulp caps, limited to

1. Silver amalgam, silicate, plastic, composite, or equivalent material approved by CareFirst

2. One filling per surface per twelve months

B. Non-Surgical periodontic services limited to once per 24 months: one full mouth treatment

1. Periodontal scaling and root planing

2. Gingival curettage

C. Simple extractions performed without general anesthesia

2.4 Class III - Major Services - Surgical

A. Surgical periodontic services limited to once per 60 months

1. One full mouth treatment

a. Osseous Surgery, including flap entry and closure

b. Gingivectomy and gingivoplasty

2. Limited or complete occlusal adjustments in connection with periodontal treatment

3. Mucogingival Surgery limited to grafts and plastic procedures; one treatment per site

B. Endodontics as required

1. Root tip removal

2. Pulpotomy for deciduous teeth

3. Root canal for permanent teeth

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

5. Root resection

C. Oral Surgical services as required

1. Surgical extractions, including impactions

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

3. Oral Surgery performed for the preparation of the mouth for dentures

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

5. General anesthesia and or IV sedation, if

a. Required for oral Surgery; and

b. Administered by a Dentist who has a permit to administer conscious sedation or general anesthesia

6. Apicoectomy

7. Hemi-section

2.5 Class IV - Major Services - Restorative

A. Services limited to once per 60 months

1. Dentures, full and/or partial

2. Fixed bridges, including crowns, inlays and onlays used as abutments for or as a unit of the bridge, and dental implants

3. Crowns, inlays, onlays and crown build-ups

4. Stainless steel crowns until the end of the year in which a Member reaches the age of 19

B. Denture adjustments and relining limited to

1. "Regular" dentures: once per 36 months, but not within six months of initial placement

2. "Immediate" dentures

a. Initial adjustment/relining after three months of placement

b. Second adjustment/relining within the first twelve months

c. Third adjustment/relining 36 months thereafter

C. Recementation of crowns, inlays, and or bridges, limited to once in any twelve (12) month period

D. Repair of prosthetic appliances, including fixed bridges, and removable dentures, full and/or partial, limited to once in any twelve (12) month period per specific area of the appliance

SECTION 3 - LIMITATIONS AND EXCLUSIONS (in addition to those found in the Evidence of Coverage)

3.1 Limitations.

A. Covered Dental Services must be performed by or under the supervision of a Dentist, within the scope of practice for which licensure or certification has been obtained.

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

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

D. CareFirst will reimburse only after all dental procedures for the condition being treated have been completed.

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

3.2 Exclusions. Benefits will not be provided for:

A. Replacement of a denture, bridge, or crown as a result of loss or theft.

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

C. Replacement of dentures, bridges, or crowns within 60 months from the date of placement or replacement for which benefits were paid in whole or in part under the terms of this Evidence of Coverage.

D. Treatment or services for temporomandibular joint disorders including but not limited to radiographs and/or tomographic surveys.

E. Gold foil fillings.

F. Dental services in connection with birth defects or mainly for Cosmetic reasons; with the following exceptions:

1. Benefits will be provided for dental services received by the Member due to trauma to whole Sound Natural Teeth when the dental services are received after the Effective Date of coverage under this Evidence of Coverage only if the Member's medical benefit plan does not provide benefits for such dental services and written proof of denial of a claim for such benefits is submitted to CareFirst, and

2. Benefits will be provided for dental services in connection with birth defects, including cleft lip or cleft palate or both, only if the Member's medical benefit plan does not provide benefits for such dental services and written proof of denial of a claim for such benefits is submitted to CareFirst.

G. Periodontal appliances.

H. Prescription drugs, including, but not limited to antibiotics administered by the Member, inhalation of nitrous oxide, injected or applied medications that are not part of the dental service being rendered, and localized delivery of chemotherapeutic agents for the treatment of a medical condition, unless specifically listed as a Covered Dental Service in this Description of Covered Services.

I. Splinting.

J. Nightguards, occlusal guards, or other oral orthotic appliances.

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

L. Intentional tooth reimplantation or transplantation.

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

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

O. Transseptal fiberotomy or vestibuloplasty.

P. Orthognathic Surgery or other oral Surgery covered under the Member's medical benefit plan.

Q. The repair or replacement of any orthodontic appliance.

R. Services or supplies that are not Medically Necessary.

S. Services not specifically listed in this Description of Covered Services as a Covered Dental Service, even if Medically Necessary.

T. Services or supplies that are related to an excluded service (even if those services or supplies would otherwise be covered services).

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

V. Telephone consultations, failure to keep a scheduled visit, completion of forms, or administrative services.

W. Services or supplies that are Experimental or Investigational in nature.

X. Services, appliances, or supplies related to orthodontic treatment.

SECTION 4 - ESTIMATE OF ELIGIBLE BENEFITS

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

CareFirst encourages a Member to obtain a written Estimate of Eligible Benefits (CareFirst's written estimate of benefits before a service is rendered) for major dental procedures, thereby alerting a Member of the out-of-pocket expenses that may be associated with the treatment plan and/or procedures that are considered non-covered services. Based on an Estimate of Eligible Benefits from CareFirst, a Member can decide whether or not to incur the expense that may be associated with the treatment.

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

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

To request an Estimate of Eligible Benefits prior to receiving dental treatment or dental procedures, a Member should contact his or her Dentist who will coordinate the request on the Member's behalf. If the Dentist has any questions about the process, he or she may contact the CareFirst Provider Services Department. The Estimate of Eligible Benefits is merely an estimate, and it cannot be considered a guarantee of the Member's benefits or enrollment under this CareFirst Evidence of Coverage.

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

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

An independent licensee of the Blue Cross and Blue Shield Association

ATTACHMENT C

SCHEDULE OF BENEFITS

The benefits and limitations described in this schedule are subject to all terms and conditions stated in the Evidence of Coverage.

CareFirst pays only for Covered Dental Services. The Member pays for services, supplies or care, which are not covered. The Member pays any applicable Deductible or Coinsurance. Services that are not listed in the Description of Covered Services, or are listed in the Exclusions and Limitations, are not Covered Dental Services.

When determining the benefits a Member may receive, CareFirst considers all provisions and limitations in the Evidence of Coverage as well as its dental policies. When these conditions of coverage are not met or followed, payments for benefits may be denied.

Benefit Period	Contract Year
Deductible	The in-network Benefit Period Deductible of $25 for an individual and $75 for a family applies to all Class II; III; and IV Covered Dental Services. The out-of-network Benefit Period Deductible of $50 for an individual and $150 for a family applies to all Class II; III; and IV Covered Dental Services. The family Deductible amount is calculated in the aggregate. However, no family Member will be charged more than the individual Deductible amount. The in-network and out-of-network Deductible will be a combined amount.
Benefit Maximum	
Benefit Period Maximum	The Benefit Period Maximum per person for all Class II; III; and IV Covered Dental Services is $1,500. The in-network and out-of-network Benefit Period Maximum will be a combined amount.

COVERED DENTAL SERVICE	SUBJECT TO DEDUCTIBLE?	MEMBER PAYS		
		Preferred Dentist	**Participating Dentist**	**Non-Participating Dentist**
Class I - Preventive & Diagnostic Services	No	No charge	No charge	Difference between the CareFirst Allowed Benefit and the Dentist billed charge
Class II - Basic Services	Yes	20% of Allowed Benefit	20% of Allowed Benefit	20% of Allowed Benefit
Class III - Major Services - Surgical	Yes	20% of Allowed Benefit	20% of Allowed Benefit	20% of Allowed Benefit
Class IV - Major Services - Restorative	Yes	50% of Allowed Benefit	50% of Allowed Benefit	50% of Allowed Benefit

(1) After the Deductible is met, Preferred Dentists accept 100% of the Allowed Benefit as payment in full for Covered Dental Services.

(2) After the Deductible is met, Participating Dentists accept 100% of the Allowed Benefit as payment in full for Covered Dental Services.

(3) Non-Participating Dentists may bill the Member for the difference (if any) between the Allowed Benefit and the Non-Participating Dentist's actual charge for Covered Dental Services

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COMPENSATION AND PREMIUM DISCLOSURE STATEMENT

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

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

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

A. METHODS OF PAYING DENTISTS

This table shows definitions of how insurance carriers may pay dentists (or other providers) for your dental care services with a simple example of how each payment mechanism works.

Terms	The example shows how Dr. Jones, a dentist, would be compensated under each method of payment.
Salary	A dentist or other provider is an employee of the HMO and is paid compensation (monetary wages) for providing specific dental care services. Since Dr. Jones is an employee of an HMO, she receives her usual bi-weekly salary regardless of how many patients she sees or the number of services she provides. If Dr. Jones provides multiple dental care services during one month to Mrs. Smith who is a member of the HMO, Dr. Jones' salary is unchanged.
Capitation	A dentist or group of dentists is paid a fixed amount of money per month by an HMO for each patient who chooses the dentist to be his or her dentist. Payment is fixed without regard to the volume of services that an individual patient requires. Under this type of contractual arrangement, Dr. Jones participates in an HMO network. She is not employed by the HMO. Her contract with the HMO stipulates that she is paid a certain amount each month for patients who select her as their dentist. Since Mrs. Smith is a member of the HMO, Dr. Jones' monthly payment does not change as a result of her providing ongoing care to Mrs. Smith. The capitation amount paid to Dr. Jones is the same whether or not Mrs. Smith requires dental care services. Depending on her type of coverage, Mrs. Smith may be responsible for paying Dr. Jones a specific copayment amount for each dental care service provided by Dr. Jones.

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

B. PERCENTAGE OF PROVIDER PAYMENT METHODS

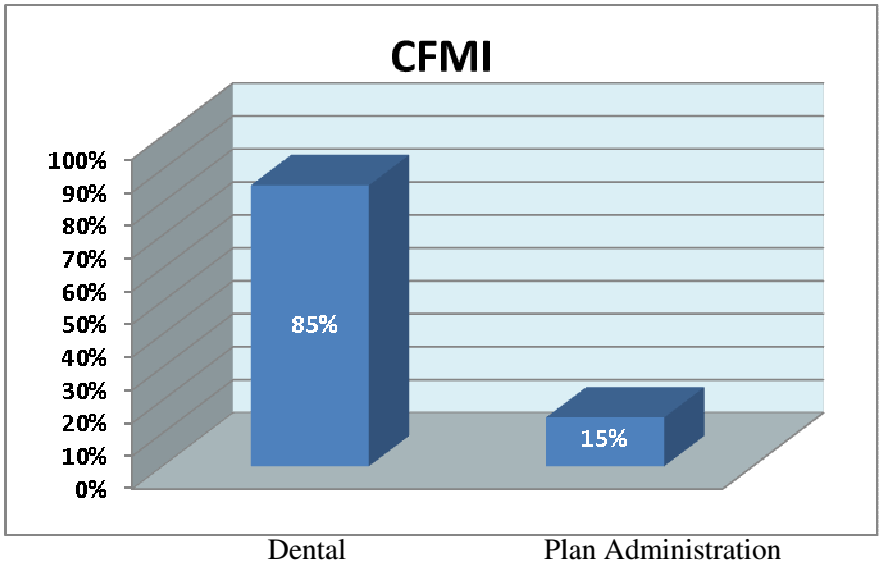
For its Indemnity and Preferred Provider Organization (PPO) products, CareFirst BlueCross BlueShield contracts directly with dentists. All dentists are reimbursed on a discounted fee-for-service basis.

C. DISTRIBUTION OF PREMIUM DOLLARS

The bar graph below illustrates the proportion of every $100 in premium used by CareFirst BlueCross BlueShield to pay providers for dental care expenses, and the proportion used to pay for plan administration.

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

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



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NOTICE OF PROTECTION PROVIDED BY MARYLAND LIFE AND HEALTH INSURANCE GUARANTY CORPORATION

This notice provides a brief summary of the Maryland Life and Health Insurance Guaranty (the Corporation) and the protection it provides for policyholders. This safety net was created under Maryland law, which determines who and what is covered and the amounts of coverage.

The Corporation is not a department or unit of the State of Maryland and the liabilities or debts of the Life and Health Insurance Guaranty Corporation are not liabilities or debts of the State of Maryland.

The Corporation was established to provide protection in the unlikely event that your life, annuity, or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Corporation will typically arrange to continue coverage and pay claims, in accordance with Maryland law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Corporation are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values
- Health Insurance
  - $500,000 for basic hospital, medical, and surgical insurance or major medical insurance provided by health benefit plans
  - $300,000 for disability insurance
  - $300,000 for long-term care insurance
  - $100,000 for a type of health insurance not listed above, including any net cash surrender and net cash withdrawal values under the types of health insurance listed above
- Annuities
  - $250,000 in the present value of annuity benefits, including net cash withdrawal values and net cash surrender values
  - With respect to each payee under a structured settlement annuity, or beneficiary of the payee, $250,000 in present value annuity benefits, in the aggregate, including any net cash surrender and net cash withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is:

- $300,000 in aggregate for all types of coverage listed above, with the exception of basic hospital, medical, and surgical insurance or major medical insurance
- $500,000 in aggregate for basic hospital, medical, and surgical insurance or major medical insurance

NOTE: Certain policies and contracts many not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Maryland law.

To learn more about the above protections, please visit the Corporation's website at www.mdlifega.org, or contact:

Maryland Life and Health
Insurance Guaranty Corporation
9199 Reisterstown Road
P.O Box 671-Suite 216C
Owings Mills, Maryland.21117
410-998-3907

Maryland Insurance
Administration
200 St. Paul Place, Suite 2700
Baltimore, Maryland.21202
1-800-492-6116, ext. 2170

Insurance companies and agents are not allowed by Maryland law to use the existence of the Corporation or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Corporation coverage. If there is any inconsistency between this notice and Maryland law, then Maryland law will control.

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

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

An independent licensee of the Blue Cross and Blue Shield Association

ATTACHMENT C

ELIGIBILITY SCHEDULE

Eligibility	
Subscriber	A full-time wage-earning employee; who works at least 30 hours per week on a regular (not seasonal or temporary) basis. NOTE: A wage earning employee is a person who is compensated for work/services performed in accordance with applicable federal and state wage and hour laws, which compensation is reported to the Internal Revenue Service by Form W-2 and the Department of Business and Economic Development by Form DEED/AU-16.
Spouse	Coverage for a Spouse is available.
Dependent Children	Coverage for children is available.
Type of Coverage	Individual, Individual & Child(ren), Individual & Adult, Family
Limiting Age for Dependent Children	Up to age 26
Limiting Age for Student Dependents	Up to age 26

Effective Dates	
Open Enrollment Effective Date	December 1, 2016
New Subscriber Eligibility Date	A new Subscriber is eligible for coverage effective on the first day of the month following the date of hire or membership in the Group.
Existing Subscriber Effective Date	An existing Subscriber is eligible for coverage on the effective date of the Group
Existing Dependent Effective Date	An existing Dependent is eligible for coverage on the effective date of the Group
Newborn, newly adopted child, stepchild, newly eligible grandchild or child subject to a MCSO/QMSO or child for whom guardianship has been granted by court or testamentary appointment	The First Eligibility Date

Newly eligible Dependent (other than newborn, newly adopted child, stepchild, newly eligible grandchild or child subject to a MCSO/QMSO or child for whom guardianship has been granted by court or testamentary appointment)	The date first eligible
Termination of Coverage	
Subscriber no longer eligible.	A Subscriber will remain covered until the end of the month in which the Subscriber first no longer meets the eligibility requirements stated in the Evidence of Coverage.
Dependent Children	End of the month following their 26th birthday
Student Dependents	End of the month following their 26th birthday
Dependent no longer eligible (includes marriage of child, divorce of Spouse, or child who is no longer a Student Dependent)	A Dependent will remain covered until the end of the month in which the Dependent no longer meets the eligibility requirements stated in the Evidence of Coverage.
Upon death of Subscriber	Coverage ends on the last day of the month after the Subscriber's death

CareFirst of Maryland, Inc.

Chester E. Burrell
President and Chief Executive Officer