Group Hospitalization and Medical Services, Inc.

doing business as
CareFirst BlueCross BlueShield (CareFirst)
[840 First Street, NE]
[Washington, DC 20065]
[202-479-8000]

An independent licensee of the Blue Cross and Blue Shield Association

INDIVIDUAL ENROLLMENT AGREEMENT
FOR A QUALIFIED HEALTH PLAN

This Qualified Health Plan is being offered through the Exchange.

This Agreement, including any notices, amendments, and riders, is issued to the Subscriber and contains the principal provisions affecting the Member(s) enrolled under the Agreement and other provisions that explain the duties of CareFirst and those of the Subscriber. The Agreement, in its entirety, is the complete contract between CareFirst and the Subscriber.

The Subscriber accepts and agrees to the Agreement by making payment to CareFirst as required under the Agreement. CareFirst agrees to the Agreement when it is issued to the Subscriber. The Subscriber's payment and CareFirst's issuance make the Agreement's terms and provisions binding on CareFirst and the Subscriber.

CareFirst may, under certain circumstances, discontinue coverage of a Member or terminate the Agreement. See Section 4 of the Agreement for additional information.

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

THE SUBSCRIBER MAY CANCEL THIS AGREEMENT WITHIN TEN (10) DAYS
The Subscriber may cancel this Agreement by notifying CareFirst or the Exchange in writing within ten (10) days of the date he or she received it. CareFirst will cancel the Subscriber's coverage at midnight on the day CareFirst or the Exchange receives the cancellation notice. CareFirst will refund any paid Premiums to the Subscriber for coverage beyond the cancellation date. If any Member utilizes Covered Services during the ten (10) day period, the Subscriber must pay for those services.

[Subscriber Name: ____]

[Subscriber ID Number: ____]

[Product Name: ____]

[Effective Date: ____]

Term: This Agreement will have an initial term from the Agreement Effective Date stated above until December 31st of that year. The Agreement will automatically be renewed from year to year on January 1st of each succeeding year unless terminated by CareFirst or the Subscriber or the Application Filer.

Group Hospitalization and Medical Services, Inc.

[Signature]
[Name]
[Title]

SECTION	TABLE OF CONTENTS	PAGE
1	Definitions	[X]
2	Eligibility and Enrollment	[X]
3	Premiums and Payment	[X]
4	Termination of Coverage	[X]
5	Coordination of Benefits (COB); Subrogation	[X]
6	General Provisions	[X]
ATTACHMENTS		
[A]	[Benefit Determinations and Appeals]	[A-1]
[B]	Description of Covered Services	[B-1]
[C]	Schedule of Benefits	[C-1]
	Amendments/Notices/Riders	

SECTION 1
DEFINITIONS

The underlined terms when capitalized are defined as follows:

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

Advance Payments of the Premium Tax Credit means payment of the tax credits specified under section 1401 of the Affordable Care Act which are provided on an advance basis to an eligible individual enrolled in a Qualified Health Plan through the Exchange.

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

Agreement means this agreement between CareFirst and the Subscriber and it includes the Individual Enrollment Agreement, *Benefit Determinations and Appeals*, Description of Covered Services, Schedule of Benefits, and any duly authorized notices, amendments, and riders.

This variation is to accommodate changes in any future filings of the benefit determinations and appeals process. A version of this form will always be attached to the Agreement.

Allowed Benefit means:

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

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

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

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

D. For a Covered Service rendered by a Non-Preferred Provider of ambulance services, the Allowed Benefit for a Covered Service is based upon the lesser of the provider's actual charge or the established fee schedule. The benefit is payable to the Member or to the Non-Preferred Provider of ambulance services, at the discretion of CareFirst. When

benefits are paid to the Member, it is the Member's responsibility to apply any CareFirst payments to the claim from the Non-Preferred Provider of ambulance services. The Member is responsible for any applicable Deductible, Copayment, or Coinsurance amounts stated in the Schedule of Benefits and the difference between the Allowed Benefit and the provider's actual charge. The provider may bill the Member directly for such amounts.

For Emergency Services provided by a Non-Preferred Provider, the Allowed Benefit for a Covered Service is based upon the lesser of the provider's actual charge, or the amount that would be paid to a Preferred Provider for the Covered Service. The Member is responsible for any applicable Deductible, Copayment, or Coinsurance amounts stated in the Schedule of Benefits and the difference between the Allowed Benefit and the practitioner's actual charge. The provider may bill the Member directly for such amounts.

<u>Pediatric Dental Allowed Benefit</u> means:

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

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

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

<u>Prescription Drug Allowed Benefit</u> means the lesser of:

A. The Pharmacy's actual charge; or

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

If the Member purchases a covered Prescription Drug or diabetic supply from a Contracting Pharmacy

Provider, the benefit payment is made directly to the Contracting Pharmacy Provider and is accepted as payment in full, except for any applicable Deductible, Copayment, or Coinsurance. The Member is responsible for any applicable Deductible, Copayment, or Coinsurance and the Contracting Pharmacy Provider may bill the Member directly for such amounts.

If the Member purchases a covered Prescription Drug from a Non-Contracting Pharmacy Provider, the Member is responsible for paying the total charge and submitting a claim to CareFirst or its designee for reimbursement. Members will be entitled to reimbursement from CareFirst or its designee in the amount of the Allowed Benefit, minus any applicable Deductible, Copayment, or Coinsurance. Members may be responsible for balances above the Allowed Benefit.

<u>Vision Allowed Benefit</u> means:

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

1. The actual charge; or

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

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

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

Benefits may be paid to the Subscriber or to the Non-Contracting Vision Provider at the discretion of the Vision Care Designee. The Member is responsible for the cost difference between the Vision Care Designee's payment and the Non- Contracting Vision Provider's actual charge. The Non-Contracting Vision Provider may bill the Member directly. It is the Member's responsibility to apply any CareFirst payments to the claim from the Non-Contracting Vision Provider.

<u>Annual Open Enrollment Period</u> means the periods during each Calendar Year, as designated by the Exchange or applicable law, during which a Qualified Individual may enroll or change coverage in a Qualified Health Plan through the Exchange.

<u>Application Filer</u> means the parent, guardian, or other representative who submits an Enrollment Application on behalf of a Qualified Individual for a Child-Only Agreement. By submitting the Enrollment Application for a Child-Only Agreement, the Application Filer agrees to be the party responsible under this Agreement for the payment of Premiums and any other amounts due from the Subscriber and to be the party responsible to provide information requested by CareFirst relating to the Subscriber's enrollment or the provision of benefits to the Subscriber.

<u>Benefit Period</u> means the Calendar Year during which coverage is provided for Covered Services, Covered Dental Services, and Covered Vision Services.

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

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

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

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

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

Child-Only Agreement means this Agreement where the Subscriber, at the time of enrollment, is under the age of nineteen (19) and has selected Child-Only Coverage.

Child-Only Coverage means coverage where the Subscriber, at the time of enrollment, is under the age of nineteen (19), will only enroll himself or herself under a Child-Only Agreement, and who will not have the right to enroll any Dependents.

Civil Union means a relationship established in accordance with the laws of another jurisdiction, other than marriage that is substantially similar to a domestic partnership established under *the Health Care Benefits Expansion Act, D.C. Code Ann. §§ 32-701 – 32-710 (2001)*, as amended, as certified by the Mayor.

This variation is to accommodate a change in the statute.

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

Contracting Pharmacy Provider means the separate independent Pharmacist or Pharmacy, including a pharmacy in the Exclusive Specialty Pharmacy Network, that has contracted with CareFirst or its designee to provide Prescription Drugs in accordance with the terms of this Agreement.

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

Convenience Item means personal hygiene and convenience items, including but not limited to; air conditioners, humidifiers, physical fitness equipment, elevators, hoyer/stair lifts, ramps, shower/bath benches, and items available without a prescription.

Copayment (Copay) means the fixed dollar amount that a Member must pay for certain Covered Services, Covered Dental Services or Covered Vision Services.
When a Member receives multiple services on the same day by the same health care provider, the Member will only be responsible for one (1) Copay.

The inclusion or exclusion of the italicized text is dependent upon plan design.

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

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

Covered Prescription Drug means a Prescription Drug included in the CareFirst Formulary.

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

Covered Specialty Drug means a Specialty Drug included in the CareFirst Formulary.

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

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

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

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

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

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 this Agreement as the eligible Spouse, Domestic Partner *Civil Union partner or legal partner* or eligible Dependent Child as defined in Sections 2.2, 2.3 and 2.4.

The inclusion or exclusion of the italicized text is dependent upon plan design.

Dependent Child or Dependent Children means one or more Qualified Individuals as defined in Section 2.4.

Diabetic Supply or Diabetic Supplies means all Medically Necessary and appropriate supplies prescribed by a health care provider for the treatment of diabetes, including but not limited to lancets, alcohol wipes, test strips (blood and urine), syringes and needles.

Domestic Partner means a person of the same or opposite sex who cohabitates/resides with the Subscriber in a Domestic Partnership, Civil Union *or legal partnership*.

The inclusion or exclusion of the italicized text is dependent upon plan design.

Domestic Partnership means a relationship between the Subscriber and Domestic Partner that meets the criteria stated in Section 2.3.

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

Emergency Medical Condition means:

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

B. With respect to a pregnant woman who is having contractions: there is inadequate time

to affect a safe transfer to another hospital before delivery, or transfer may pose a threat to the health or safety of the woman or the unborn child.

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

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

B. Such further medical examination and treatment, to the extent they are within the capability of the staff and facilities available at the hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)) to stabilize the Member. The term to "stabilize" with respect to an Emergency Medical Condition, has the meaning given in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3))).

Enrollment Application means the information submitted by or on behalf of an individual to the Exchange in connection with a request to enroll as either a Subscriber or Dependent.

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

Exclusive Specialty Pharmacy Network means a pharmacy network that is limited to certain specialty Pharmacies that have been designated as "Exclusive" by CareFirst. Members may contact CareFirst for a list of Pharmacies in the Exclusive Specialty Pharmacy Network.

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

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

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

C. The Technology must improve the net health outcome;

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

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

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

FDA means the United States Food and Drug Administration.

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

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

Formulary means the means the list of Prescription Drugs issued by CareFirst and used by health care providers when writing, and Pharmacists, when filling, prescriptions for which coverage will be provided under this Agreement. CareFirst may change this list periodically without notice to

Members. A copy of the Formulary is available to the Member upon request.

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

Habilitative Services mean health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

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

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

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

Immediate Family means the Spouse, Domestic Partner, *Civil Union partner, legal partner*, parents, siblings, grandparents, and children of the terminally ill Member.

The inclusion or exclusion of the italicized text is dependent upon plan design.

Infusion Services means treatment provided by placing therapeutic agents into the vein, and parenteral administration of medication and nutrients. Infusion services also include enteral nutrition, which is the delivery of nutrients by tube into the gastrointestinal tract. Infusion Services include all medications administered intravenously and/or parenterally.

Limiting Age means the maximum age to which a Dependent Child may be covered. The Limiting Age is the age of twenty-six (26).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Medication-Assisted Treatment (MAT) means Prescription Drugs used to treat Substance Use Disorders (Alcohol Use Disorder and opioid use disorder).

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

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

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

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

Non-Preferred Brand Name Drug means a Brand Name Drug included in the Formulary as a Covered Prescription Drug but not included on the Preferred Drug List.

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

Non-Preferred Provider means a health care provider that does not contract with CareFirst to provide

Covered Services. Neither Participating Dentists or Non-Participating Dentists who provide Covered Dental Services nor Non-Contracting Vision Providers who provide Covered Vision Services are Non-Preferred Providers for the purposes of this definition.

Non-Preferred Specialty Drug means a Specialty Drug included in the Formulary as a Covered Prescription Drug but not included on the Preferred Drug List.

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

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

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

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

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

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

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

Preferred Drug List means the list of Preferred Drugs issued by CareFirst and used by health care providers when writing, and Pharmacists, when filling, prescriptions. All Generic Drugs are included in the Preferred Drug List. Not all Brand Name Drugs listed in the Formulary are included in the Preferred Drug List. CareFirst may change this list periodically without notice to Members. A copy of the Preferred Drug List is available to the Member upon request.

Preferred Provider means a health care provider that has contracted with CareFirst to render Covered Services to Members. A Preferred Dentist who provides Covered Dental Services or a Contracting Vision Provider who provides Covered Vision Services is not a Preferred Provider for the purposes of this definition. Preferred Provider relates only to method of payment, and does not imply that any physician, health care professional or health care facility is more or less qualified than another.

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

Preferred Specialty Drug means a Specialty Drug included in the Preferred Drug List.

Premium means the dollar amount the Subscriber remits for health care benefits.

Premium Due Date is the first day of the month for the period for which the Premium applies.

Prescription Drug means:

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

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

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

D. Any Diabetic Supply.

E. Prescription Drugs do not include:

1 Compounded bulk powders that contain ingredients that:

a) Do not have FDA approval for the route of administration being compounded, or

b) Have no clinical evidence demonstrating safety and efficacy, or

c) Do not require a prescription to be dispensed.

2. Compounded drugs that are available as a similar commercially available Prescription Drug unless:

a) There is no commercially available bioequivalent Prescription Drug; or

b) The commercially available bioequivalent Prescription Drug has caused or is likely to cause the Member to have an adverse reaction.

Prescription Guidelines means the limited list of Prescription Drugs issued by CareFirst for which providers, when writing, and Pharmacists, when filling prescriptions, must obtain prior authorization from CareFirst and the quantity limits that CareFirst has placed on certain drugs. A copy of the Prescription Guidelines is available to the Member upon request.

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

Preventive Drug List means the list issued by CareFirst of Prescription Drugs or Over-the-Counter medications or supplies dispensed under a written prescription by a health care provider that have been identified in the current recommendations of the United States Preventive Services Task Force that have in effect a rating of “A” or “B” or as provided in the comprehensive guidelines for women’s preventive health supported by the Health Resources and Services Administration. CareFirst may change this list periodically and without notice to Members. A copy of the Preventive Drug List is available to the Member upon request.

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

Primary Care Physician (PCP) means health care practitioners in the following disciplines:

A. General internal medicine;

B. Family practice medicine;

C. General pediatric medicine; or

D. Geriatric medicine.

Services rendered by Specialists in the disciplines above will be treated as PCP visits for Member payment purposes.

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

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

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

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

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

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

Qualified Individual means an individual who has been determined by the Exchange to be eligible to enroll.

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

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

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

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

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

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

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

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

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

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

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

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

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

Subscriber means the Qualified Individual to whom this Agreement has been issued.

Substance Use Disorder means:

A. Alcohol Use Disorder means a disease that is characterized by a pattern of pathological use of alcohol with repeated attempts to control its use, and with negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social; or

B. Drug Use Disorder means a disease that is characterized by a pattern of pathological use of a drug with repeated attempts to control the use, and with negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social.

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

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

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

SECTION 2
ELIGIBILITY AND ENROLLMENT

2.1 Requirements for Coverage.

A. The Subscriber must be a Qualified Individual;

B. Any Dependent must be a Qualified Individual; and

C. The Subscriber and any Dependent must timely enroll as provided in Section 2.7 and CareFirst or the Exchange must receive Premium payments for each enrolled Member.

D. Child-Only Agreement. This Agreement is issued as a Child-Only Agreement where an eligible Qualified Individual or Application Filer submits an Enrollment Application to the Exchange that requests Child-Only Coverage for the Subscriber. The following apply to Child-Only Agreements:

1. The Subscriber must be a Qualified Individual under age nineteen (19) at the time of enrollment under a Child-Only Agreement; and

2. Only the Subscriber may enroll in a Child-Only Agreement. Coverage for Dependents is not available and the Subscriber has no right to enroll any Dependent.

3. Sections 2.1B, 2.2, 2.3, 2.4, 2.5 and the provisions related to the enrollment or termination of Dependents stated in Section 2.6 and Section 4 are omitted and are inapplicable to a Child-Only Agreement.

4. The only Type of Coverage available for a Child-Only Agreement is Subscriber only.

2.2 Eligibility of Subscriber's Spouse. The Subscriber may enroll a Qualified Individual that is his or her Spouse as a Dependent. A Subscriber cannot cover a former Spouse once divorced or if the marriage had been annulled. Premium changes resulting from the enrollment of a Spouse will be effective as of the Effective Date of the Spouse's enrollment.

2.3 Eligibility of a Subscriber's Domestic Partner. Domestic Partner means a person of the same or opposite sex who cohabitates/resides with the Subscriber in a Domestic Partnership, Civil Union [or legal partnership]. (See Section 1, Definitions, for the definitions of Domestic Partnership and Civil Union.)

A. Requirements for Coverage. To be eligible for coverage as the Domestic Partner of a Subscriber, the following conditions must be met:

1. The individual must be eligible for coverage as a Domestic Partner as defined in Section 2.3(B);

2. The Subscriber must elect coverage for his/her Domestic Partner; and

3. Premium payments must be made as required under this Agreement.

B. Domestic Partnership means a relationship between a Subscriber and a Domestic Partner that satisfies the requirements of either section below:

1. The Subscriber and the Domestic Partner:

a) Are currently registered as Domestic Partners in the District of Columbia in accordance with the [Health Care Benefits Expansion Act, D.C. Code

Ann. §§ 32-701 – 32-710 (2001)], as amended; or

b) Are in a Civil Union. Civil Union means a relationship established in accordance with the laws of another jurisdiction, other than marriage that is substantially similar to a domestic partnership established under the [Health Care Benefits Expansion Act, D.C. Code Ann. §§ 32-701 – 32-710 (2001)], as amended, as certified by the Mayor.

2. If the requirement in Section 2.3(B)(1) above has not been met, the Subscriber and Domestic Partner must meet all of the following requirements:

a) The Subscriber and the Domestic Partner are the same sex or opposite sex and both are at least eighteen (18) years of age and have the legal capacity to enter into a contract;

b) The Subscriber and the Domestic Partner are not parties to a legally recognized marriage with anyone else and are not in a civil union or domestic partnership with anyone else;

c) The Subscriber and Domestic Partner are not related to the other by blood or marriage within four (4) degrees of consanguinity under civil law rule;

d) The Subscriber and Domestic Partner share a common primary residence. The Subscriber must submit one (1) of the following documents as proof of a shared common primary residence:

(1) Common ownership of the primary residence via joint deed or mortgage agreement;

(2) Common leasehold interest in the primary residence;

(3) Driver's license or State-issued identification listing a common address; or

(4) Utility or other household bill with both the name of the Subscriber and the Domestic Partner appearing; and

e) The Subscriber and Domestic Partner are Financially Interdependent and submit documentary evidence of their committed relationship of financial interdependence existing for at least six (6) consecutive months prior to application.

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

1. Joint bank account or credit account;

2. Designation of one partner as the other's primary beneficiary with respect to life insurance or retirement benefits;

3. Designation of one partner as the primary beneficiary under the other partner's will;

4. Mutual assignments of valid durable powers of attorney under the applicable

laws of any state or the District of Columbia;

5. Mutual valid written advanced directives under the applicable laws of any state or the District of Columbia, approving the other partner as health care agent;

6. Join ownership or holding of investments; or

7. Joint ownership or lease of a motor vehicle.

2.4 Eligibility of Dependent Children. The Subscriber may enroll a Qualified Individual who is an eligible Dependent Child. A Qualified Individual who is the child of Domestic Partner is eligible for coverage as any other Dependent Child, if the Domestic Partner and the child of the Domestic Partner meet the qualifications for coverage. A Dependent Child means a Qualified Individual who:

A. Is:

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

2. A child placed with the Subscriber, the Subscriber's Spouse or the Subscriber's eligible Domestic Partner for legal Adoption;

3. An individual under testamentary or court appointed guardianship, other than temporary guardianship for less than twelve (12) months' duration, of the Subscriber, the Subscriber's Spouse, or the Subscriber's eligible Domestic Partner; or

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

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

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

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

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

5. A child who becomes a Dependent of the Subscriber through a child support order or other court order.

B. Is under the Limiting Age of twenty-six (26); or

C. Is a Qualified Individual who is the subject of a Medical Child Support Order that creates or recognizes the right of the child to receive benefits under the health insurance coverage of the Subscriber, the Subscriber's covered Spouse or the Subscriber's covered Domestic Partner.

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

E. Premium changes resulting from the enrollment of a Dependent Child will be effective as of the Effective Date of the Dependent Child's enrollment.

2.5 Limiting Age for Covered Dependent Children.

A. All covered Dependent Children are eligible up to the Limiting Age of twenty-six (26).

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

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

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

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

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

C. The coverage of a Dependent will terminate if a Dependent Child reaches the Limiting Age or if there is a change in their status or relationship of the Dependent to the Subscriber, such that they no longer meet the eligibility requirements of this Agreement.

2.6 Open Enrollment Opportunities and Effective Dates. Qualified Individuals may elect coverage as a Subscriber or Member, as applicable, only during the following times and under the following conditions.

A. Annual Open Enrollment. During an Annual Open Enrollment Period, a Qualified Individual may enroll as a Subscriber or Dependent through the Exchange.

B. Special Enrollment. If a Qualified Individual does not enroll during an Annual Open Enrollment Period, he or she may only enroll through the Exchange during a Special Enrollment Period.

Except as otherwise provided, during a Special Enrollment Period, a Qualified Individual not currently enrolled in a QHP may enroll in any QHP. In addition, a Qualified Individual currently enrolled a QHP may enroll in another QHP within the same metal level of coverage, or one metal level higher or lower if the same metal level of coverage is not available. A Dependent of a Qualified Individual currently enrolled in a QHP may be added to the Qualified Individual's current QHP, may enroll with the Qualified Individual in another QHP within the same level of coverage (or one metal level higher or lower if no such QHP is available), or may enroll in any separate QHP.

These limitations do not apply to Section 2.6B.1.(i) (plan enrollment for Indians), Section 2.6B.1.(d) (Exchange errors or non-Exchange errors), Section 2.6B.1.(j) (exceptional circumstances), Section 2.6B.1.(m) (victim of domestic violence). For Qualified Individuals using a Special Enrollment Period pursuant to Section 2.6B.1.(i) (plan

enrollment for Indians), Section 2.6B.1.(d) (Exchange errors or non-Exchange errors), Section 2.6B.1.(j) (exceptional circumstances), Section 2.6B.1.(m) (victim of domestic violence), the Qualified Individual or the Dependent of a Qualified Individual may enroll in or change to any QHP regardless of whether the Qualified Individual or Dependent of a Qualified Individual is currently enrolled in a QHP.

1. A Qualified Individual may enroll as a Subscriber or Dependent upon the occurrence of one of the following qualifying events:

a) The Qualified Individual or a Dependent:

(1) Loses Minimum Essential Coverage. A loss of Minimum Essential Coverage includes those circumstances described in 26 CFR 54.9801-6(a)(3)(i) through (iii).

Loss of coverage described herein includes those circumstances described in 26 CFR 54.9801-6(a)(3)(i) through (iii) and in paragraphs (d)(1)(ii) through (iv) of 45 CFR §155.420. Loss of coverage does not include voluntary termination of coverage or other loss due to:

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

(b) Situations allowing for a Rescission.

(2) Is enrolled in any non-Calendar Year health insurance policy even if the Qualified Individual or his or her Dependent has the option to renew non-Calendar Year health insurance policy. The date of the loss of coverage is the last day of the non-Calendar Year policy year.

(3) Loses pregnancy-related coverage described in 1902(a)(10)(A)(i)(IV) and (a)(10)(A)(ii)(IX) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)(IV), (a)(10)(A)(ii)(IX)). The date of the loss of coverage is the last day the consumer would have pregnancy-related coverage; or

(4) Loses medically needy coverage as described under section 1902(a)(10)(C) of the Social Security Act only once per Calendar Year. The date of the loss of coverage is the last day the consumer would have medically needy coverage.

(5) At the option of the Exchange, loses a dependent or is no longer considered a dependent through divorce or legal separation or if the Subscriber or his or her Dependent dies.

b) A Qualified Individual gains, or becomes, a Dependent through marriage, birth, adoption, placement for adoption, grant of court or testamentary guardianship, child support order (MCSO) or other court order, or placement of a child for foster care. The foster child is not eligible for coverage under this Agreement.

In this instance, if the Qualified Individual and any Dependents are not currently enrolled in a QHP, the Qualified Individual and any Dependents (except for a foster child) may enroll in any QHP. If the Qualified Individual's current QHP does not allow the dependent to

enroll in the same QHP, the Qualified Individual and any Dependents can enroll in different QHP of the same metal level or one metal level higher or lower. In the case of marriage, at least one Spouse must demonstrate having minimum essential coverage for one or more days during the sixty (60) days preceding the date of marriage unless one Spouse can demonstrate that he or she lived in a foreign country or in a US territory for one (1) or more days during the sixty (60) days preceding the marriage.

c) The Qualified Individual or his or her Dependent was not previously a citizen, national, or lawfully present in the United States and gains such status.

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

e) The Qualified Individual is enrolled in an employer-sponsored plan that is not qualifying coverage in an employer-sponsored plan and is allowed to terminate coverage.

f) The Qualified Individual or his or her Dependent, who is an enrollee in another Qualified Health Plan, demonstrates to the Exchange that the other Qualified Health Plan in which he or she has enrolled substantially violated a material provision of its contract in relation to the Qualified Individual.

g) A Qualified Individual or his or her Dependent:

(1) is determined newly eligible or newly ineligible for advance payments of the premium tax credit, or has a change in eligibility for cost-sharing reductions;

(2) who enrolled in the same Qualified Health Plan is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions; or,

(3) who is enrolled in an eligible employer-sponsored plan is determined newly eligible for Advance Payments of the Premium Tax Credit based in part on a finding that such individual is ineligible for qualifying coverage in an eligible-employer sponsored plan in accordance with 26 CFR 1.36B-2(c)(3), including as a result of his or her employer discontinuing or changing available coverage within the next 60 days, provided that such individual is allowed to terminate existing coverage.

(4) is a Qualified Individual who was previously ineligible for advance payments of the premium tax credit solely because of a household income below 100 percent of the federal poverty level and who, during the same timeframe, was ineligible for Medicaid because he or she was living in a non-Medicaid expansion State, who either experiences a change in household income or moves to a different State resulting in the Qualified Individual becoming newly eligible for Advance Payments of the

Premium Tax Credit.

h) The eligible individual or his or her Dependent becomes eligible as a result of a permanent move and either:

(1) had minimum essential coverage as described in 26 CFR 1.5000A-1(b) for one or more days during the sixty (60) days preceding the date of the permanent move; or,

(2) was living in a foreign country or in a United States territory for one or more days during the sixty (60) days preceding the date of the permanent move.

The eligible individual or his or her Dependent may access this Special Enrollment Period sixty (60) days before or after the date of the permanent move.

i) The Qualified Individual is an Indian, as defined in section 4 of the Indian Health Care Improvement Act, who may enroll in a Qualified Health Plan or change coverage from one Qualified Health Plan to another one time per month or who is or becomes a Dependent of an Indian, as defined by section 4 of the Indian Health Care Improvement Act and is enrolled or is enrolling in a Qualified Health Plan through an Exchange on the same application as the Indian, may change from one Qualified Health Plan to another one time per month, at the same time as the Indian.

j) The Qualified Individual or his or her Dependents demonstrates to the Exchange, in accordance with guidelines issued by the United States Department of Health and Human Services that he or she meets other exceptional circumstances determined by the Exchange.

k) It is determined by the Exchange that a Qualified Individual or his or her Dependent was not enrolled in Qualified Health Plan coverage; was not enrolled in the Qualified Health Plan selected; or is eligible for but not receiving advance payments of the premium tax credit or cost-sharing reductions as a result of misconduct on the part of a non-Exchange entity providing enrollment assistance or conducting enrollment activities.

For the purposes of this provision, misconduct includes, but is not limited to, the failure of the non-Exchange entity to comply with applicable standards, 45 CFR §155, 45 CFR §156, or other applicable Federal or State laws, as determined by the Exchange.

l) The eligible individual or his or her Dependent becomes eligible for coverage as a result of a release from incarceration.

m) The eligible individual or his or her Dependent:

(1) is a victim of domestic abuse or spousal abandonment, as defined by 26 CFR 1.36B-2T, as amended, including a dependent or unmarried victim within a household, is enrolled in minimum essential coverage and seeks to enroll in coverage separate from the perpetrator of the abuse or abandonment; or,

(2) is a dependent of a victim of domestic abuse or spousal abandonment, on the same application as the victim, may enroll in coverage at the same time as the victim.

n) The eligible individual or his or her Dependent:

(1) applies for coverage on the Exchange during the annual open enrollment period or due to a qualifying event, is assessed by the Exchange as potentially eligible for Medicaid or the Children's Health Insurance Program (CHIP), and is determined ineligible for Medicaid or CHIP by the State Medicaid or CHIP agency either after open enrollment has ended or more than 60 days after the qualifying event; or

(2) applies for coverage at the State Medicaid or CHIP agency during the annual open enrollment period, and is determined ineligible for Medicaid or CHIP after open enrollment has ended;

o) The eligible individual, or his or her Dependent, adequately demonstrates to the Exchange that a material error related to plan benefits, Service Area, or Premium influenced the eligible individual's decision to purchase a QHP through the Exchange.

p) At the option of the Exchange, the Qualified Individual provides satisfactory documentary evidence to verify his or her eligibility for an insurance affordability program or enrollment in a QHP through the Exchange following termination of Exchange enrollment due to a failure to verify such status within the time period specified in 45 CFR §155.315 or is under 100 percent of the Federal poverty level and did not enroll in coverage while waiting for HHS to verify his or her citizenship, status as a national, or lawful presence.

2. With the exception of the qualifying events described in Section 2.6B.1.a) and 2.6B.1.g)(3) above, the Special Enrollment Period for the qualifying events listed above shall be the sixty (60) calendar days after the date of the qualifying event, unless otherwise provided by the Exchange. In the case of a qualifying event under Section 2.6B.1.a), a Qualified Individual or his or her Dependent has 60 calendar days before and after the loss of coverage to select a Qualified Health Plan and in the case of a qualifying event under Section 2.6B.1.g)(3), a Qualified Individual or his or her Dependent has 60 calendar days before and after the loss of eligibility for qualifying coverage in an eligible employer-sponsored plan to select a Qualified Health Plan.

C. Effective Dates.

1. Annual Open Enrollment Effective Dates. The Effective Date for an eligible individual who timely enrolls during an Annual Open Enrollment Period is based on the date during the Annual Open Enrollment Period that the eligible individual enrolled. The Effective Date shall be the date established in 45 CFR §155.410(f), or the date established by the Exchange.

2. The Effective Date for an eligible individual who gains or becomes a Dependent as described in Section 2.6B.1.b) and who enrolls during a Special Enrollment Period is the Dependent Child's First Eligibility Date:

a) First Eligibility Date means

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

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

(a) A judicial decree of Adoption; or

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

(3) For a Dependent Child for whom guardianship has been granted by court or testamentary appointment or the date of the appointment.

(4) For a child placed for foster care, the date of the placement by the foster care agency or the first of the month following the date of placement by the foster care agency at the Subscriber's option (if approved by the Exchange). The foster child is not eligible for coverage under the Agreement.

(5) For a child subject to a child support order (MCSO or other court order), the date of the child support order.

b) The Dependent Child will be covered automatically, but only for the first thirty-one (31) days following the child's First Eligibility Date. The Subscriber must enroll such a Dependent Child within sixty (60) days of the child's First Eligibility Date when an additional Premium is due for the enrollment of the Dependent Child. Otherwise, the Dependent Child will not be covered beyond thirty-one (31) days and cannot be enrolled until the next Annual Open Enrollment Period. (An additional Premium will be due unless there are three (3) or more Dependent Children under the age of twenty-one (21) already enrolled by the Subscriber.)

3. The Effective Date for a Qualified Individual who gains or becomes a new Dependent through marriage who enrolls during a Special Enrollment Period shall be the first of the month following plan selection.

4. If the Subscriber or his or her Dependent dies as stated in 2.6B.1(a)(5), the Effective Date is the first of the month following plan selection or as determined by the Exchange.

5. The Effective Date for a Qualified Individual or Dependent who loses coverage as described in Section 2.6B.1.a), 2.6B.1.g)(3) or 2.6B.1g)(4) who enrolls during a Special Enrollment Period shall be the first day of the month following loss of coverage if the plan selection is made before or on the day of the loss of coverage. If the plan selection is made after the loss of coverage, the Effective Date of coverage is as described in Section 2.6C.7. The effective date for a Qualified Individual who gains coverage as described in Section 2.6B.1.h) who enrolls during a Special Enrollment Period shall be the first day of the month following the date of the permanent move or release from incarceration if the plan selection is made on or before the date of the permanent move or release from incarceration. If the plan selection is made after the date of the permanent move or release from incarceration, the Effective Date of coverage is as described in Section 2.6C.7.

6. The Effective Date for a Qualified Individual or Dependent who enrolls due to a qualifying event stated in (i) Section 2.6B.1.d) (enrollment or non-enrollment was unintentional, inadvertent, or erroneous and is the result of an error by the Exchange or the United States Department of Health and Human Services), (ii) Section 2.6B.1.f) (a Qualified Health Plan substantially violated a material provision of its contract), (iii) Section 2.6B.1.j) (other exceptional circumstances as determined by the Exchange), (iv) Section 2.6B.1.k) (misconduct by a non-Exchange entity as determined by the Exchange), (v) Section 2.6B.1.n) (deemed

eligible or applied for Medicaid or CHIP coverage and was subsequently denied), (vi) Section 2.6B.1.o) (demonstrates that a material error occurred), and (vii) Section 2.6B.1.p) (termination of enrollment due to non-timely verification of eligibility by the Exchange) shall be the appropriate date based on the circumstances of the Special Enrollment Period as determined by the Exchange.

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

a) For enrollment received by the Exchange between the first and the fifteenth (15th) day of the month, the first day of the following month; and

b) For enrollment received by the Exchange between the sixteenth (16th) and the last day of the month, the first day of the second following month.

8. At the option of the Qualified Individual, the Exchange will provide an appropriate coverage effective date that is later than the effective date specified in the provisions of this section if the Qualified Individual's enrollment is delayed until after the Exchange's verification of the Qualified Individual 's eligibility for a Special Enrollment Period, and the assignment of an Effective Date consistent with the provisions in this section would result in the Qualified Individual being required to pay two or more months of retroactive premium to effectuate coverage or avoid termination for non-payment.

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

2.7 Child Support Orders (MCSO or QMSO).

A. Eligibility and Termination.

1. Upon receipt of an MCSO or QMSO, CareFirst will accept enrollment of a child who is the subject of an MCSO or QMSO. Coverage will be effective as of the date of the order, and the Premium will be adjusted as needed. If the Subscriber does not enroll the child then CareFirst will accept enrollment from the non-Subscriber custodial parent; or, the appropriate child support enforcement agency of any state or the District of Columbia.

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

a) Was born out of wedlock;

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

c) Does not reside with the Subscriber; or

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

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

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

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

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

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

1. Send to the non-insuring custodial parent the identification cards, claims forms, the applicable Agreement and any information needed to obtain benefits;

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

3. Provide benefits directly to:

a) The non-insuring parent;

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

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

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

2.9 Cooperation and Submission of Information. The Subscriber agrees to cooperate with and assist CareFirst and/or the Exchange, including providing CareFirst and the Exchange with reasonable access to eligibility records upon request. At any time coverage is in effect, CareFirst reserves the right to request documentation substantiating eligibility and to provide any information it receives regarding a Member's eligibility to the Exchange.

2.10 If the Exchange has required CareFirst or any of its affiliates to renew the Subscriber's medical benefit plan outside of the Exchange, CareFirst shall terminate the individual medical benefit plan that the Subscriber has outside of the Exchange with CareFirst or any of its affiliates without any further action by the Subscriber the day before the Effective Date of this Agreement if:

1. The Subscriber has applied on the Exchange for an Advanced Premium Tax Credit or Cost-Sharing Reduction;

2. The Exchange has determined that the household is eligible for an Advanced Premium Tax Credit or Cost-Sharing Reduction; and,

3. The Subscriber has paid the Subscriber's portion of the Premium for this Agreement.

For purposes of this provision, Advance Premium Tax Credit means tax credits specified under section 1401 of the Affordable Care Act which are provided on an advance basis to an eligible individual enrolled in a Qualified Health Plan through the Exchange. For purposes of this provision, Cost-Sharing Reduction means an affordability program under Section 1402 of the Affordable Care Act.

If the Exchange does not require CareFirst or any of its affiliates to renew the medical benefit plan outside of the Exchange as referenced above, then this provision will not be applied.

SECTION 3
PREMIUMS AND PAYMENT

3.1. Premiums. The initial Premium is due on or before the Effective Date of this Agreement. Subsequent Premiums are due on the Premium Due Date. The Premium Due Date is the first day of the month for the period for which the Premium applies. The initial Premium is required to effectuate coverage under this Agreement.

If the Subscriber elects an electronic payment, CareFirst will not debit or charge the amount of the Premium due prior to the Premium Due Date, except as authorized by the Subscriber.

3.2 Grace Period.

A. Grace Period Applicable Where the Members do not Receive Advance Payments of the Premium Tax Credit. Except for the initial Premium and as provided in Section 3.2B, there is a grace period of thirty-one (31) days beginning on the Premium Due Date within which overdue Premiums can be paid without loss of coverage. The grace period begins on the Premium Due Date. The grace period of thirty-one (31) days will be granted for the payment of each Premium falling due after the initial Premium, during which coverage shall continue in force. If Premiums are not received by the Premium Due Date, CareFirst or the Exchange will notify the Subscriber in writing of the overdue Premiums. If CareFirst or the Exchange receives payment of all amounts listed on the notice prior to the end of this grace period, coverage will continue without interruption. If CareFirst or the Exchange does not receive full payment of all amounts listed on the notice prior to the end of this grace period, the Agreement, and the enrollment of the Subscriber and any Dependents, shall be terminated as set forth in Section 4.2B.

B. Grace Period for Recipients of Advance Payments of the Premium Tax Credit. If a Subscriber or Member (i) receives Advance Payments of the Premium Tax Credit, made to them by the Exchange or to CareFirst on their behalf, and (ii) has paid at least one month's full Premium due during the Calendar Year, there is a grace period of three (3) months beginning on the Premium Due Date within which overdue Premiums can be paid without loss of coverage. The grace period begins on the Premium Due Date. If Premiums are not received by the Premium Due Date, CareFirst will notify the Subscriber in writing of the overdue Premiums. This grace period will apply as follows:

1. If CareFirst or the Exchange receives payment of all Premiums due prior to the end of this grace period, coverage will continue without interruption.

2. If CareFirst or the Exchange does not receive payment of all Premiums due prior to the end of this grace period, this Agreement, and the enrollment of the Subscriber and any Dependents, shall be terminated as set forth in Section 4.2B.

3. The grace period provided in Section 3.2A above shall not apply if the Subscriber receives the grace period under this provision.

3.3 Reinstatement. A Subscriber may apply for reinstatement of a terminated policy if the Subscriber believes the policy was terminated due to an error by CareFirst or the Exchange. All reinstatement requests must be approved by the Exchange and may be declined. Under no circumstances will CareFirst or the Exchange automatically reinstate a terminated policy.

3.4 Premium Adjustments. All Premium adjustments for Members enrolling or terminating during a coverage month will be calculated on a pro-rated basis. Calculated Premium adjustments will be

applied to the next month's Premium charges as follows:

A. New enrollment may result in additional Premium charges depending upon the Subscriber's current coverage.

B. Terminations may result in a credit toward the Premium charges due. If termination due to death of a Member resulted in an overpayment of Premiums on the Subscriber's part, CareFirst will retroactively adjust the Premium payments but for no more than sixty (60) days retroactively from the date CareFirst or the Exchange received the notice of the change.

3.5 Premium Rate Changes. There may be a rate increase when approved by the District of Columbia Department of Insurance, Securities and Banking, as provided by law. CareFirst will not increase the Subscriber's Premium more frequently than once every Calendar Year. CareFirst will provide notice of the change to Premiums by giving the Subscriber at least forty-five (45) days prior written notice. Any change in Premium rates, including changes in a Member's Premium rate due to a change in a Member's age, will be effective on January 1st of each year this Agreement renews.

CareFirst may increase the Subscriber's Premium more frequently than once every twelve (12) months if the increase is due solely to the enrollment of a new Dependent.

SECTION 4
TERMINATION OF COVERAGE

4.1 Termination of Enrollment by the Subscriber.

A. The Subscriber or Application Filer may terminate his or her enrollment under the Agreement at any time by notifying the Exchange. CareFirst will be notified of the termination by the Exchange.

B. Only in the manner permitted by the Exchange, a Subscriber may terminate the enrollment of a Dependent by notifying the Exchange. CareFirst will be notified of the termination by the Exchange.

C. The date of a termination of a Member or this Agreement, when initiated by the Subscriber, will be:

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

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

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

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

4.2 Termination of Agreement by CareFirst or the Exchange. CareFirst or the Exchange may terminate the Agreement or the enrollment of a Subscriber and/or a Dependent under the following circumstances by providing notice of termination, including the termination date and the reason for termination, to the Subscriber or Application Filer promptly and without undue delay.

A. Termination for Ineligibility.

1. The Member is no longer a Qualified Individual eligible to enroll in a Qualified Health Plan through the Exchange. If the Subscriber is no longer eligible for coverage under this Agreement, the Agreement will be terminated. Any Dependents of the terminated Subscriber who remain eligible to enroll in a Qualified Health Plan through the Exchange may do so.

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

3. The Effective Date of Termination.

a) Under Sections 4.2A.1 and 4.2A.2, the effective date of termination will be the last day of the month that the Member is no longer eligible for coverage unless otherwise instructed by the Exchange, except when a Dependent is no longer eligible for coverage under this Agreement due to reaching the Limiting Age. The Member, as applicable, may request an earlier termination date as provided in Section 4.1

b) When a Dependent is no longer eligible due to reaching the Limiting Age, the effective date of termination will be December 31 of the Calendar Year in which the Dependent reaches the Limiting Age, unless otherwise instructed by the Exchange.

4. The Subscriber is responsible for notifying the Exchange of any changes in the status of a Member as a Qualified Individual or his or her eligibility for coverage, except when the Dependent Child reaches the Limiting Age. These changes include a death or divorce. If the Subscriber knows of a Member's ineligibility for coverage and intentionally fails to notify the Exchange, CareFirst has the right to seek Rescission of the coverage of the Member or the Agreement under Section 4.3 as of the initial date of the Member's ineligibility. In such a case, CareFirst has the right to recover the full value of the services and benefits provided during the period of the Member's ineligibility. CareFirst can recover these amounts from the Subscriber and/or any terminated Member, at the option of CareFirst, less any Premium paid for the Member's enrollment during the period of ineligibility.

B. <u>Termination of Agreement for Non-Payment of Premiums</u>. In the case of a termination of this Agreement for non-payment of Premiums by the Subscriber, the date of termination, after the expiration of the applicable grace period, shall be as follows:

1. Termination of Agreement Where the Subscriber does not Receive Advance Payments of the Premium Tax Credit. If CareFirst or the Exchange does not receive payment of an overdue Premium prior to the end of the thirty-one (31) day grace period set forth in Section 3.2A, the Agreement, and the enrollment of the Subscriber and any Dependents, will terminate effective as of the last day of this grace period. The Subscriber will be liable for the full cost of all services or benefits received by any Member on or after the date of termination of this Agreement, except as provided in this Agreement.

2. Termination of Agreement Where the Subscriber Receives Advance Payments of the Premium Tax Credit. If CareFirst or the Exchange does not receive the overdue Premium by the end of the three (3) month grace period set forth in Section 3.2B, the Agreement, and the enrollment of the Subscriber and any Dependents, shall be terminated as the last day of the first month of the three (3) month grace period set forth in Section 3.2.B. The Subscriber will be liable for the full cost of all services or benefits received by any Member on or after the date of termination except as provided in this Agreement.

C. <u>Termination due to the Decertification of the Agreement as a Qualified Health Plan</u>. If this Agreement is Decertified as a Qualified Health Plan, the date of termination of this Agreement shall be the date established by the Exchange after written notice has been provided to the Subscriber and the Subscriber has been afforded an opportunity to enroll in other coverage.

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

E. Additional Causes for Terminations. Termination may be initiated for the following causes:

1. The Subscriber no longer resides, lives or works in the Service Area. In such a case, the enrollment of the Subscriber and all Dependents will be terminated with ninety (90) days prior written notice.

F. Termination Based on Medicare Entitlement or Enrollment. Members entitled to or enrolled in Medicare may be terminated within thirty-one (31) calendar days of initial effectuation of the Agreement unless the Agreement is a renewal of a contract of insurance for the same policy

4.3 Rescission of Enrollment for Fraud or Misrepresentation. This Agreement, or the enrollment of a Member, may be Rescinded if:

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

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

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

D. CareFirst demonstrates, to the reasonable satisfaction of the Exchange, if required by the Exchange, that the rescission is appropriate.

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

4.4 Death of Dependent. In case of the death of a Dependent, the enrollment of the deceased Dependent shall terminate on the date the Dependent's death occurs, unless otherwise provided by the Exchange.

4.5 Death of Subscriber. In case of the death of the Subscriber, this Agreement shall terminate on the date of the Subscriber's death if there are no Dependents enrolled under this Agreement. If Dependents are enrolled, this Agreement shall terminate on the last day of the month in which the Subscriber's death occurs.

4.6 Effect of Termination. No benefits will be provided for any services received on or after the date on which this Agreement terminates. This Section includes services received for an injury or illness that occurred before the date of termination.

SECTION 5
COORDINATION OF BENEFITS (COB); SUBROGATION

5.1 Coordination of Benefits (COB).

A. Applicability.

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

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

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

b) May be coordinated when, under the order of determination rules, another Plan determines its benefits first. The coordination is explained in Section 5.1D.2.

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

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

CareFirst Plan means this Agreement.

Dental Plan means any dental insurance policy, including those of nonprofit health service plans, and those of commercial group, blanket, and individual policies, any subscriber contracts issued by Health Maintenance Organizations (HMOs), and any other established programs under which the insured may make a claim. The term Dental Plan includes coverage under a governmental plan, or coverage required to be 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.)

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

Plan means any health insurance policy issued on a group basis, including those of a nonprofit health service plan, those of a commercial, group, and blanket policy, any subscriber contracts issued by health maintenance organizations, and any other established programs under which the insured may make a claim. The term Plan includes coverage required or provided by law and coverage under a governmental plan, except a governmental plan which, by law, provides benefits in excess of those of any private insurance plan or other non-governmental plan. This does not include a state plan under

Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).

The term Plan does not include:

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

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

3. Coverage regulated by a motor vehicle reparation law;

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

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

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

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

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

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

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

C. Order of Benefit Determination Rules.

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

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

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

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

   a) Non-dependent/dependent. The benefits of the Plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the Plan which covers the person as a dependent; except if the person is also a Medicare

beneficiary, and the result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

f) Medical and Dental Plan. When one of the plans is a medical plan and the other is a Dental Plan, and a determination cannot be made in accordance with the above, the medical plan should be considered as the Primary Plan.

D. <u>Effect on the Benefits of this CareFirst Plan</u>.

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

2. Coordination in this CareFirst Plan's Benefits. When this CareFirst Plan is the

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

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

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

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

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

2. Insurance companies; or

3. Other organizations.

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

5.2 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 Agreement. Benefits covered by Medicare are subject to the provisions in this section.

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

B. Medicare as Primary.

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

such claim payment by Medicare.

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

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

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

B. From any federal, state, county or municipal or other government agency, including, in the case of service-connected disabilities, the United States Department of Veterans Affairs, to the extent 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.

5.4 Subrogation

A. 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. Subrogation applies to any illness or injury which is:

1. Caused by an act or omission of a third party; or

2. Covered under a member's uninsured or underinsured policy issued to or otherwise covering the Member; or

3. Covered by No Fault Insurance. No Fault Insurance means motor vehicle casualty insurance. This term also refers to motor vehicle insurance issued under any other state or federal legislation of similar purpose.

B. If the Member receives or is entitled to receive payment from any person, organization or entity in connection with an injury, illness or need for care for which benefits were provided or will be provided under this Agreement, the payment will be treated as having been paid to the Member as a recovery for the medical, hospital and other expenses for which CareFirst provided or will provide benefits. CareFirst may recover the amounts paid or will pay in benefits up to the amount received from or on behalf of the third party or applicable first party coverage.

All recoveries the Member or the Member's representatives obtain (whether by lawsuit, settlement, insurance or benefit program claims, or otherwise), no matter how described or designated (for example as "pain and suffering"), must be used to reimburse CareFirst in full for benefits paid. CareFirst's share of any recovery extends only to the amount of benefits paid or payable to the Member, the Member's representatives, and/or health care providers on the Member's behalf. For purposes of this provision, "Member's representatives" include, if applicable, heirs, administrators, legal representatives, parents (if the Member is a minor), successors, or assignees. This is CareFirst's right of recovery.

C. CareFirst's right of recovery is not subject to reduction for attorney's fees and costs under the "common fund" or any other doctrine. If required by law, CareFirst will reduce the

amount owed by the Member to CareFirst in accordance with applicable law.

D. CareFirst will have a lien on all funds the Member recovers up to the total amount of benefits provided. We are entitled under our right of recovery to be reimbursed for our benefit payments even if you are not "made whole" for all of your damages in the recoveries that you receive. CareFirst may give notice of that lien to any party who may have contributed to the Member's loss, or who may be liable for payment as a result of that loss.

E. CareFirst has the option to be subrogated to the Member's rights to the extent of the benefits provided under this Agreement. This includes CareFirst right to bring suit or file claims against the third party in the Member's name.

F. Members agree to take action, furnish information and assistance, and execute such instruments that CareFirst may require while enforcing CareFirst rights under this Section. The Member agrees to not take any action which prejudices CareFirst's rights and interests under this provision.

SECTION 6
GENERAL PROVISIONS

6.1 Entire Agreement; Changes. The entire agreement between CareFirst and the Subscriber includes: (a) the Individual Enrollment Agreement; (b) [Benefit Determinations and Appeals]; (c) the Description of Covered Services; (d) Schedule of Benefits; and (e) any additional duly authorized notices, amendments and riders.

No amendment or modification of any term or provision of this Agreement shall be valid until approved by an executive officer of CareFirst. Any duly authorized notice, amendment or rider will be issued by CareFirst to be attached to the Agreement. No agent has authority to change this Agreement or to waive any of its provisions. Any waiver of an Agreement term or provision shall only be given effect for its stated purpose and shall not constitute or imply any subsequent waiver.

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

6.2 Claims and Payment of Claims.

A. Claim Forms. 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. If CareFirst does not provide the claim forms within fifteen (15) days after notice of claim is received, the claimant is deemed to have complied with the requirements of the policy as to proof of loss if the claimant submits, within the time fixed in the policy for filing proof of loss, written proof of the occurrence, character, and extent of the loss for which the claim is made.

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

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

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

3. Provide benefits directly to:

    a) The non-insuring, custodial parent;

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

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

B. Proof of Loss.

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

For Covered Services provided by Non-Preferred Providers, Non-Participating Dentists, Non-Contracting Vision Providers, and Non-Contracting Pharmacies, Members must

furnish written proof of loss, or have the provider submit proof of loss, to CareFirst within one (1) year after the date of the loss. The Member is also responsible for providing information requested by CareFirst including, but not limited to, medical records.

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

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

C. Time of Payment of Claims. Except as provided in this paragraph, benefits payable will be paid immediately after receipt of written proof of loss. Claims for services rendered after expiration of the first month of the grace period for recipients of Advance Payments of the Premium Tax Credit, as set forth in Sections 3.2B. and 4.2B.2., will be pended and will only be paid after the Subscriber makes payment of the Premium due. Any accrued benefits unpaid at the Member's death shall be paid to the Member's estate.

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 paid in error. If the Member has not repaid the full amount owed CareFirst and CareFirst makes a subsequent benefit payment, CareFirst may subtract the amount owed CareFirst from the subsequent payment.

E. Payment of Claims. Payments for Covered Services will be made by CareFirst directly to Contracting Vision, Participating and Preferred Dentists and Preferred Providers. Direct payments will also be made by CareFirst to providers from the United States Department of Defense and the United States Department of Veteran Affairs. If a Member receives Covered Services from Non-Contracting Vision or Non-Preferred Providers, CareFirst reserves the right to pay either the Member or the provider'. If the Member has paid the health care provider for services rendered, benefits will be payable to the Member.

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

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

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

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

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

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

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

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

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

6.9 Member Privacy. CareFirst shall comply with state, federal and local laws pertaining to the dissemination or distribution of non-public personally identifiable financial, medical or health related data. In that regard, CareFirst will not provide to unauthorized third parties any personally identifiable financial or medical information without the prior written authorization of the Member or parent/guardian of the Member or as otherwise permitted by law. Personal information, including email addresses and phone numbers, may be used and shared with other businesses who work with CareFirst to administer and/or provide benefits under this plan. Personal information, as described below, may also be used to notify enrollees about treatment options, health-related services, and/or coverage options. Enrollees may contact CareFirst to change the information used to communicate with them.

The more complete information health care providers have, the better they can meet the Members' health care needs. Sharing information and data with the Member's treating providers can lead to better coordinated care, help the Member get timely care, limit duplicative services, and help the provider better identify patients who would benefit most from care management and other care coordination programs.

How we use medical information to enhance or coordinate the Member's care — In order to administer the Member's health benefits, CareFirst receives claims data and other information from the Member's various providers of care regarding diagnoses, treatments, programs and services provided under your health plan. Individual treating providers, however, may not have access to information from the Member's other providers. When CareFirst has such information, it may share it with the Member's treating providers through secure, electronic means solely for purposes of enhancing or coordinating the Member's care and to assist in clinical decision making.

The Member may Opt-Out of information sharing by CareFirst for these care coordination purposes. The Member has the right to opt-out of the sharing of this information by CareFirst with his/her treating provider for care coordination purposes at any time. To opt-out, the Member must complete, sign and return the *Opt-Out of Medical Information Sharing* Form found at www.carefirst.com/informationsharing. **When the Member submits this form, the Member also ends participation in any of the programs listed in this Agreement that require the sharing of information to enhance or coordinate care. If the Member opts out, his/her treating providers will not have access to the data or information CareFirst has available to help enhance or coordinate his/her care.**

6.10 CareFirst's Relationship to Providers. Health care providers, including Preferred Providers, Preferred or Participating Dentists, Contracting Vision Providers, and Contracting Pharmacy Providers, are independent contractors or organizations and are related to CareFirst by contract only. Preferred Providers, Preferred or Participating Dentists, Contracting Vision Providers, and Contracting Pharmacy Providers are not employees or agents of CareFirst and are not authorized to act on behalf of or obligate CareFirst with regard to interpretation of the terms of the

Agreement, including eligibility of Members for coverage or entitlement to benefits. Preferred Providers, Preferred or Participating Dentists, Contracting Vision Providers, and Contracting Pharmacy Providers maintain a provider-patient relationship with the Member and are solely responsible for the professional services they provide. CareFirst is not responsible for any acts or omissions, including those involving malpractice or wrongful death of Preferred Providers, Preferred or Participating Dentists, Contracting Vision Providers, Contracting Pharmacy Providers, or any other individual, facility or institution which provides services to Members or any employee, agent or representative of such providers.

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

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

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

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

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

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

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

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

6.14 Notices.

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

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

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

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

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

6.15 Amendment Procedure. Except for Premium rate changes, CareFirst will amend this Agreement to implement modifications made pursuant to Section 6.22 by mailing a notice of the

amendment(s) to the Subscriber, via first class mail or electronically if the Member has consented to receive such notices via electronic mail, before the date of the next annual open enrollment period.

If the material modification required by law is made at a time other than renewal, and if it affects the content of the summary of benefits and coverage, CareFirst will provide advance notice at least sixty (60) days before the effective date of the modification.

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

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

6.17 Records and Clerical Errors.

A. The Subscriber must furnish CareFirst with data and notifications required for coverage in the format approved by CareFirst.

B. Clerical errors in recording or reporting data will not alter this Agreement. Upon discovery, adjustments will be made to remedy the errors.

6.18 Applicable Law. This Agreement is entered into and is subject to the laws of the District of Columbia. All claims arising from this Agreement will be brought and maintained in the District of Columbia. The Members consent to the jurisdiction of the District of Columbia for all actions arising from this Agreement.

6.19 Contestability of Agreement.

A. The Agreement may not be contested, except for nonpayment of Premium, after it has been in force for two (2) years from the date of issue;

B. Absent fraud, each statement made by an applicant or Member is considered to be a representation and not a warranty; and

C. A statement to effectuate coverage may not be used to avoid the coverage or reduce the benefits unless:

1. The statement is contained in a written instrument signed by the Subscriber or Member, and

2. A copy of the statement is given to the Subscriber or Member.

No statement contained within this provision precludes the assertion at any time of defenses based upon the person's ineligibility for coverage or upon other provisions in this Agreement.

6.20 Misstatement of Age. If the age of a Member has been misstated, all Premiums payable under this Agreement shall be calculated based on the Premium due based on the Member's correct age. If the correction of the Member's age results in an increase in the Premium due, the Subscriber shall pay CareFirst or the Exchange the increased Premium due by the next Premium Due Date after notification by CareFirst or the Exchange. If, due to the correction in the Member's age, a Subscriber has paid a Premium, or portion of a Premium, not due, CareFirst's liability is limited to a refund, on request, of any excess Premium paid for the period during which the Member's

age was misstated.

6.21 Notice of Address Change. The Subscriber must notify CareFirst within fifteen (15) days of a change in residence or change in e-mail address, if the Member has consented to receive notices via electronic mail, or as soon as reasonably possible. Except in the case of a covered child who does not reside with the Subscriber, CareFirst is only responsible for mailing notices or correspondence to the last known physical address or e-mail address of the Subscriber.

6.22 Uniform Modification. CareFirst reserves the right to modify the Agreement at renewal if the modification is consistent with State law and is effective uniformly for all individuals with this product.

A. For purposes of this provision, modifications made uniformly and solely pursuant to applicable Federal or State requirements are considered a uniform modification of coverage if:

1. The modification is made within a reasonable time period after the imposition or modification of the Federal or State requirement; and

2. The modification is directly related to the imposition or modification of the Federal or State requirement.

B. For purposes of this provision, other types of modifications made uniformly are considered a uniform modification of coverage if the health insurance coverage for the product meets all of the following criteria:

1. The product is offered by the same health insurance issuer (within the meaning of section 2791(b)(2) of the PHS Act);

2. The product is offered as the same product network type (for example, health maintenance organization, preferred provider organization, exclusive provider organization, point of service, or indemnity);

3. The product continues to cover at least a majority of the same service area;

4. Within the product, each plan has the same cost-sharing structure as before the modification, except for any variation in cost sharing solely related to changes in cost and utilization of medical care, or to maintain the same metal tier level described in sections 1302(d) and (e) of the Affordable Care Act; and

5. The product provides the same covered benefits, except for any changes in benefits that cumulatively impact rate for any plan within the product within an allowable variation of ± 2 percentage points (not including changes pursuant to applicable Federal or State requirements).

6.23 Agreement Solely Between the Subscriber and CareFirst. The Subscriber, on behalf of himself / herself and the Subscriber's Dependents, hereby expressly acknowledges the Subscriber's understanding that this Agreement constitutes a contract solely between the Subscriber and CareFirst; CareFirst is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association") permitting CareFirst to use the Blue Cross and Blue Shield Service Marks in the District of Columbia, the state of Maryland and portions of the Commonwealth of Virginia, and CareFirst is not contracting as the agent of the Association. The Subscriber, on behalf of himself/herself and any Dependents, further acknowledges and agrees it has not entered into this Agreement based upon representations by any person other than CareFirst; and no person, entity, or organization other than CareFirst shall be held accountable or liable to the Subscriber for any of CareFirst's obligations to the Subscriber. This paragraph shall not create any additional obligations whatsoever on the part of CareFirst other than those obligations created under other

provisions of this Agreement.

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

6.25 Credit Monitoring. CareFirst is offering credit monitoring to the Subscriber and eligible Dependents at no additional charge through services administered by [Experian]. Credit monitoring is available on an opt-in basis for all eligible Members during the effective Benefit Period of their CareFirst health insurance policy. Eligible Members may enroll by calling [800-XXX-XXXX] or visiting [www.carefirst.com].