

SCHEDULE OF BENEFITS

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

When determining the benefits a Member may receive, CareFirst considers all provisions of the Contract, its medical policies, and its operating procedures. When these policies and procedures are not followed, payments for benefits may be denied. Certain Utilization Management Requirements may apply. When these requirements are not met, payments may be denied or reduced.

DEDUCTIBLES	
In-Network Deductible	Out-Of-Network Deductible
<p>The Individual Deductible is \$750 per Benefit Period.</p> <p>The Family Deductible is \$1,500 per Benefit Period.</p> <p>The following amounts apply to the In-Network Deductible:</p> <p>100% of the Allowed Benefit for covered In-Network services that are subject to the In-Network Deductible, as stated in the Benefits chart below.</p>	<p>The Individual Deductible is \$750 per Benefit Period.</p> <p>The Family Deductible is \$1,500 per Benefit Period.</p> <p>The following amounts apply to the Out-of-Network Deductible:</p> <p>100% of Allowed Benefit for covered Out-of-Network services that are subject to the Out-of-Network Deductible, as stated in the Benefits chart below.</p>
In and Out-of-Network Deductibles	
<p>If the Member has Individual Coverage, he or she must meet the Individual Deductible</p> <p>When Members are covered under Two-Party Coverage, each Member must satisfy his or her own Deductible by meeting the Individual Deductible.</p> <p>Members covered under Family Coverage can satisfy their own Deductible by meeting the Individual Deductible. Once one family member satisfies the Individual Deductible, the expenses of all remaining covered family members may be combined to satisfy the remaining Family Deductible.</p> <p>The following amounts may <u>not</u> be used to satisfy the In-Network OR Out-of-Network Deductibles:</p> <ul style="list-style-type: none"> • Copayments • Amounts incurred for failure to comply with the Utilization Management Program requirements • The portion of any provider charge that is in excess of the Allowed Benefit • Coinsurance, Copayments or Deductible(s) if any, for services covered under any Rider or Attachment, unless specifically provided in the Rider or Attachment. • Amounts incurred for all services covered under Section 10 Vision Care Services <p>The Benefit chart, below, identifies whether a Covered Service is subject to a Deductible. If a Deductible applies, the chart will also indicate whether a Deductible applies to In-Network benefits, Out-of-Network benefits, or both.</p>	

OUT-OF-POCKET LIMITS	
In-Network	Out-Of-Network
<p>The Individual Out-of-Pocket Limit is \$3,000 per Benefit Period.</p> <p>The Family Out-of-Pocket Limit is \$6,000 per Benefit Period.</p> <p>These amounts apply to the In-Network Out-of-Pocket Limit:</p> <ul style="list-style-type: none"> • Coinsurance for Covered In-Network Services; • Copayments for Covered In-Network Services; • The In-Network Deductible; <p>When a Member reaches the In-Network Out-of-Pocket Limit, no further Coinsurance or Copayments will be required in that Benefit Period for In-Network services subject to the Out-of-Pocket Limit.</p>	<p>The Individual Out-of-Pocket Limit is \$4,000 per Benefit Period.</p> <p>The Family Out-of-Pocket Limit is \$8,000 per Benefit Period.</p> <p>These amounts apply to the Out-of-Network Out-of-Pocket Limit:</p> <ul style="list-style-type: none"> • Coinsurance for Covered Out-of-Network Services; • The Out-of-Network Deductible; <p>When a Member has reached the Out-of-Network Out-of-Pocket Limit, no further Coinsurance will be required in that Benefit Period for Out-of-Network services subject to the Out-of-Pocket Limit.</p>

In-Network and Out-Of-Network Out-of-Pocket Limit

If the Member has Individual Coverage, the Member must meet the Individual Out-of-Pocket Limit

When Members are covered under Two-Party Coverage, each Member must satisfy his or her own Out-of-Pocket Limit by meeting the Individual Out-of-Pocket Limit.

Members covered under Family Coverage can satisfy their own Out-of-Pocket Limit by meeting the Individual Out-of-Pocket Limit. In addition, if 2 covered family members separately meet their own Individual Out-of-Pocket Limits, this will also satisfy the Out-of-Pocket Limit for all other covered family members.

The following amounts may not be used to meet the In-Network or Out-of-Network Out-of-Pocket Limits:

- Coinsurance or Copayments, if any, for services covered under an Attachment, unless specifically provided in the Attachment;
- Coinsurance or Copayments for services covered under Section 10 Vision Care Service
- Amounts incurred for failure to comply with the Utilization Management Program requirements;
- The portion of any provider charges which is in excess of the Allowed Benefit.

UTILIZATION MANAGEMENT NON-COMPLIANCE

Failure or refusal to comply with Utilization Management Requirements will result in:

Benefits for health care facility services associated with your care or treatment will be reduced by 50%.

LIFETIME MAXIMUM

There is an unlimited Lifetime Maximum per Member combined in and out-of-network.

BENEFITS				
SERVICE	SPECIAL LIMITATIONS	PROGRAM COVERS		
		IN-NETWORK	SUBJECT TO DEDUCTIBLES ?	OUT-OF NETWORK
PHYSICIAN AND PROVIDER SERVICES				
Preventive Services				
Child Wellness	Up to age 18 (Including related lab tests and immunizations)	100% of the Allowed Benefit	NO	70% of the Allowed Benefit
Adult Preventive Physical Examinations	Age 18 and over (Including related lab tests and immunizations)	100% of the Allowed Benefit	Out-of-Network Deductible applies	70% of the Allowed Benefit
PSA Test		100% of the Allowed Benefit	NO	70% of the Allowed Benefit
Colorectal Cancer Screening Tests		100% of the Allowed Benefit	Out-of-Network Deductible applies	70% of the Allowed Benefit
Screening Mammography	Age 40 and above One preventive mammogram (of each breast) per Benefit Period	100% of the Allowed Benefit	NO	100% of the Allowed Benefit
Routine Pap Smears	None	100% of the Allowed Benefit	NO	100% of the Allowed Benefit
Diagnostic and Treatment Services				
Office Visits		100% of the Allowed Benefit, minus a Member Copayment of \$25 per visit	NO	70% of the Allowed Benefit
Allergy Injections		80% of the Allowed Benefit	YES	70% of the Allowed Benefit
Diagnostic Lab, X-Ray and Machine Tests Radiation Therapy, Chemotherapy (injection or intravenous)		80% of the Allowed Benefit	YES	70% of the Allowed Benefit
Outpatient Rehabilitation (physical, speech, occupational therapy)	Limited to diagnoses that are expected to show significant improvement within 90 days	100% of the Allowed Benefit, minus a Member Copayment of \$35 per visit	NO	70% of the Allowed Benefit

SERVICE	SPECIAL LIMITATIONS	PROGRAM COVERS		
		IN-NETWORK	SUBJECT TO DEDUCTIBLES ?	OUT-OF NETWORK
Diagnostic and Treatment Services (continued)				
Spinal Manipulation	Benefits for chiropractic/spinal manipulation services are limited to Members who are twelve (12) years of age or older	100% of the Allowed Benefit, minus a Member Copayment of \$35 per visit	NO	70% of the Allowed Benefit
Private Duty Nursing	Limited to 100 visits per Benefit Period	80% of the Allowed Benefit	YES	70% of the Allowed Benefit
Maternity and Related Services				
Maternity Care (Office Visit)		100% of the Allowed Benefit, minus a Member Copayment of \$35 per visit	NO	70% of the Allowed Benefit
Maternity Care	Applies only to professional services, including prenatal care, delivery and post-natal care	80% of the Allowed Benefit	YES	70% of the Allowed Benefit
Surgical Care				
	Benefits apply on an inpatient or outpatient basis	80% of the Allowed Benefit	YES	70% of the Allowed Benefit
Inpatient Physician and Health Care Practitioner Services and Consultations				
	Unlimited visits; Covered only if hospitalization qualifies for coverage	80% of the Allowed Benefit	YES	70% of the Allowed Benefit
Inpatient Ancillary Services, Including Radiology and Pathology				
	Covered only if hospitalization qualifies for coverage	80% of the Allowed Benefit	YES	70% of the Allowed Benefit
Anesthesia Service				
	Benefits apply on an inpatient or outpatient basis when provided in connection with a covered procedure	80% of the Allowed Benefit	YES	70% of the Allowed Benefit
Ambulance Service				
To or From Hospital		80% of the Allowed Benefit	YES	70% of the Allowed Benefit
Foreign Transportation	Applies only if Member is traveling outside the U.S.	Not Applicable	YES	70% of the Allowed Benefit

SERVICE	SPECIAL LIMITATIONS	PROGRAM COVERS		
		IN-NETWORK	SUBJECT TO DEDUCTIBLES ?	OUT-OF NETWORK
HOSPITAL SERVICES				
Inpatient Hospital Services				
Inpatient Medical	Limited to 365 days per confinement (A new confinement begins only if the Member does not receive inpatient Hospital Services for 60 consecutive days) Must be authorized in advance under utilization management program Preferred Providers will handle In-Network utilization management requirements on Member's behalf	80% of the Allowed Benefit, minus a Member Copayment of \$200 per admission	YES	70% of the Allowed Benefit, minus a Member Copayment of \$200 per admission
Outpatient Hospital Services				
Emergency Room Treatment	Care must be for a bona-fide Medical Emergency	80% of the Allowed Benefit	YES	Covered as an In-Network benefit for a bona-fide emergency
Cardiac Rehabilitation (Hospital/facility)		80% of the Allowed Benefit	YES	70% of the Allowed Benefit
HOME HEALTH CARE				
	Limited to 90 visits (up to four hours per visit) per Benefit Period A new episode of care begins if the Member does not receive Home Health Care for the same or a different condition for 60 consecutive days Must be authorized in advance under utilization management program Preferred Providers will handle In-Network utilization management requirements on Member's behalf	80% of the Allowed Benefit	YES	70% of the Allowed Benefit

SERVICE	SPECIAL LIMITATIONS	PROGRAM COVERS		
		IN-NETWORK	SUBJECT TO DEDUCTIBLES ?	OUT-OF NETWORK
SKILLED NURSING FACILITY SERVICES				
	<p>Limited to 100 days per Benefit Period</p> <p>A new episode of care begins if the Member does not receive Home Health Care for the same or a different condition for 60 consecutive days</p> <p>Must be authorized in advance under utilization management program</p> <p>Preferred Providers will handle In-Network utilization management requirements on Member's behalf</p>	80% of the Allowed Benefit	YES	70% of the Allowed Benefit

SERVICE	SPECIAL LIMITATIONS	PROGRAM COVERS		
		IN-NETWORK	SUBJECT TO DEDUCTIBLES ?	OUT-OF NETWORK
HOSPICE CARE SERVICES				
	<p>Must be authorized in advance under utilization management program</p> <p>Preferred Providers will handle In-Network utilization management requirements on Member's behalf.</p> <p>Services limited to maximum 180 day Hospice Eligibility Period</p> <p>Inpatient care limited to 60 days per Hospice Eligibility Period.</p> <p>Family counseling limited to \$500 per Hospice Eligibility Period</p> <p>Bereavement services limited to \$100 per Hospice Eligibility Period (covered only if provided within 90 days following the Member's death)</p> <p>Additional "reserve" benefits (up to 45 days) apply if the Member exceeds:</p> <ul style="list-style-type: none"> • The Hospice Eligibility Period and/or • The inpatient benefit limit 	80% of the Allowed Benefit	YES	70% of the Allowed Benefit
MENTAL HEALTH AND SUBSTANCE ABUSE CARE				
Medication Management Office visits	None	100% of the Allowed Benefit, minus a Member Copayment of \$35 per day	Out-of-Network Deductible applies	70% of the Allowed Benefit

SERVICE	SPECIAL LIMITATIONS	PROGRAM COVERS		
		IN-NETWORK	SUBJECT TO DEDUCTIBLES ?	OUT-OF NETWORK
MENTAL HEALTH AND SUBSTANCE ABUSE CARE (continued)				
Mental Health Outpatient Services				
		100% of the Allowed Benefit, minus a Member Copayment of \$35 per day	NO	70% of the Allowed Benefit
Mental Health Inpatient Services				
	Must be authorized in advance under utilization management program Preferred Providers will handle In-Network utilization management requirements on Member's behalf.	80% of the Allowed Benefit, minus a Member Copayment of \$200 per admission	YES	70% of the Allowed Benefit, minus a Member Copayment of \$200 per admission
Inpatient Visits	Covered only if hospitalization qualifies for coverage	80% of the Allowed Benefit	YES	70% of the Allowed Benefit
Partial Hospitalization				
	Partial hospitalization days can be substituted for or combined with Hospital days for Mental Health care up to annual limits described above for "Inpatient Hospital Services"	100% of the Allowed Benefit, minus a Member Copayment of \$35 per day	Out-of-Network Deductible applies	70% of the Allowed Benefit
Substance Abuse Outpatient Services				
		100% of the Allowed Benefit, minus a Member Copayment of \$35 per day	Out-of-Network Deductible applies	70% of the Allowed Benefit

SERVICE	SPECIAL LIMITATIONS	PROGRAM COVERS		
		IN-NETWORK	SUBJECT TO DEDUCTIBLES ?	OUT-OF NETWORK
Substance Abuse Inpatient Services				
	Must be authorized in advance under utilization management program Preferred Providers will handle In-Network utilization management requirements on Member's behalf.	80% of the Allowed Benefit, minus a Member Copayment of \$200 per admission	YES	70% of the Allowed Benefit, minus a Member Copayment of \$200 per admission
Inpatient Visits	Covered only if hospitalization qualifies for coverage	80% of the Allowed Benefit	YES	70% of the Allowed Benefit
MEDICAL DEVICES AND SUPPLIES				
		80% of the Allowed Benefit	YES	70% of the Allowed Benefit

EXCLUSIONS AND LIMITATIONS

11.1 Medically Necessary (or Medical Necessity). Coverage will not be provided for any service, supply or item that is not Medically Necessary. Although a service may be listed as covered, benefits will be provided only if the service is Medically Necessary as determined by CareFirst.

11.2 Free Care. Coverage will not be provided for the cost of services that:

- A. are furnished without charge;
- B. would normally be furnished to the Member without charge; or
- C. would have been furnished to the Member without charge if the Member were not covered either under the Program or under any other health benefits arrangement.

11.3 Routine Care of Feet. Coverage will not be provided for routine, palliative, or cosmetic foot care (except for conditions determined by CareFirst to be Medically Necessary), including flat foot conditions, supportive devices for the foot, treatment of subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toe nails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet.

11.4 Routine Dental Care. Coverage will not be provided for routine dental care such as services, supplies, or charges directly related to the care, filling, removal or replacement of teeth, the treatment of disease of the teeth, gums or structures directly supporting or attached to the teeth. Benefits may be provided under a separate Attachment.

11.5 Oral Surgery. Except as otherwise provided in Section 3.10, Dental Services and Oral Surgery Services, all other procedures involving the teeth or areas surrounding the teeth including the shortening of the mandible or maxillae for cosmetic purposes or for correction of malocclusion are excluded.

11.6 Cosmetic Services. Coverage will not be provided for Cosmetic Services (except for Mastectomy—Related Services and services for cleft lip or cleft palate or both).

11.7 Prescription Drugs. Except as provided in a separate Attachment to this Contract, benefits will not be provided for prescription drugs, unless administered to the Member in the course of covered outpatient or inpatient treatment. Take-home prescriptions or medications, including self-administered injections which can be administered by the patient or by an average individual who does not have medical training, or medications which do not medically require administration by or under the direction of a physician are not covered, except as may be provided in a separate Attachment to this Contract, even though they may be dispensed or administered in a physician or provider office or facility.

11.8 Organ and Tissue Transplants. Coverage is not provided for:

- A. Non-human organs and their implantation. This exclusion will not be used to deny Medically Necessary, non-experimental skin grafts that are covered under the Contract.
- B. Any Hospital or professional charges related to any accidental injury or medical condition for the donor of the transplant material.
- C. Any charges related to transportation, lodging, and meals unless authorized or approved by CareFirst.
- D. Services for a Member who is an organ donor when the recipient is not a Member.
- E. Any service, supply or device related to a transplant that is not listed as a benefit in the Contract.

11.9 Neuromuscular Rehabilitation. Neuromuscular rehabilitation will be covered if limited to physical therapy services.

11.10 Other Exclusions. Coverage will not be provided for the following

- A. Services or supplies received before the effective date of the Member's coverage under this Agreement.
- B. Treatment of sexual dysfunctions or inadequacies limited to surgical implants for impotence (medical therapy and psychiatric treatment are not covered).
- C. Any procedure or treatment designed to alter an individual's physical characteristics to those of the opposite sex.
- D. Medical or surgical treatment for obesity, unless otherwise specified in the Description of Covered Services.

Medical or surgical treatment or regimen for reducing or controlling weight for morbid obesity.
- E. Speech therapy, occupational therapy or physical therapy, unless CareFirst determines the Member's condition is subject to improvement. Speech therapy for cleft lip and cleft palette is, however, covered. Coverage does not include nonmedical ancillary services such as vocational rehabilitation, employment counseling, or educational therapy.
- F. Fees or charges relating to fitness programs, weight loss or weight control programs, physical conditioning, exercise programs, physical conditioning, and use of passive or patient-activated exercise equipment.
- G. Medical or surgical treatment of myopia or hyperopia, including radial keratotomy and other forms of refractive keratoplasty or any complications thereof.
- H. Services to the extent they are covered by any governmental unit, except that services provided in Veteran's Administration or armed forces facilities, such as for non-service connected disabilities, for which the Member is liable will be covered.
- I. Services or supplies for injuries or diseases related to an enrolled Member's job to the extent the covered person is required to be covered by a workers' compensation law.
- J. Services or supplies resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy, excluding no-fault insurance.
- K. Services that are beyond the scope of the license of the provider performing the service.
- L. Except for covered ambulance services, travel expenses, whether or not recommended by an Eligible Provider.
- M. Services or supplies for conditions that State or local laws, regulation, ordinances, or similar provisions require to be provided in a public institution.
- N. Services or supplies received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar persons or groups.
- O. Contraceptive devices, or supplies.
- P. Partial removal of a nail without the removal of the matrix.

- Q. Infertility Services.
Coverage will not be provided for medical or surgical treatment for infertility, except as stated in the Description of Covered Services.
- R. Services solely on court order or as a condition of parole or probation unless approved by CareFirst.
- S. Any illness or injury caused by war (a conflict between nation states), declared or undeclared, including armed aggression.
- T. Any service, supply or procedure which is not specifically listed in this Description of Covered Services as a covered benefit.
- U. Biofeedback services.
- V. Premarital lab work required by law.
- W. Inpatient private duty nursing services.
- X. Services that are Experimental/Investigational or for any treatment, procedure, facility, equipment, drug, drug usage, device or supply which in CareFirst's judgment is not in accordance with accepted medical or psychiatric practices and standards in effect at the time the service in question is rendered.
- Y. Treatment rendered by a Health Care Provider who is the Member's parent, child, grandparent, grandchild, sister, brother, great grandparent, great grandchild, aunt, uncle, niece, or nephew or resides in the Member's home.
- Z. All non-prescription drugs, medications, biologicals, and Over-the-Counter disposable supplies, routinely obtained and self-administered by the Member, except as stated in the Description of Covered Services.
- AA. Any service related to recreation activities. This includes, but is not limited to, sports, games, equestrian activities and athletic training, even though such services may be deemed to have therapeutic value.
- BB. Non-medical, Health Care Provider services, including, but not limited to:
1. Telephone consultations, charges for failure to keep a scheduled visit, completion of forms, copying charges or other administrative services provided by the Health Care Provider or his/her staff;
 2. Administrative fees charges by a Health Care Provider to a Member to retain the Health Care Provider's medical practices services, e.g., "concierge fees" or boutique medical practice membership fees. Benefits under this Contract are limited to Covered Services rendered to a Member by a Health Care Provider.
- CC. Services related to human reproduction other than specifically described in this Contract including, but not limited to maternity services for surrogate motherhood or surrogate uterine insemination, unless the surrogate mother is a Member.
- DD. Treatment of temporomandibular joint disorders unless otherwise stated.
- EE. Services performed or prescribed by or under the direction of a person who is not a Health Care Provider.

- FF. Services performed or prescribed by or under the direction of a person who is acting beyond his/her scope of practice.
- GG. Habilitative Services.
- HH. Hair prostheses.
- II. Work hardening programs. Work hardening programs are highly specialized rehabilitation programs designed to simulate workplace activities and surroundings in a monitored environment with the goal of conditioning the participant for a return to work.