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

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

An independent licensee of the Blue Cross and Blue Shield Association

EVIDENCE OF COVERAGE RENEWAL AMENDMENT

CareFirst of Maryland, Inc., doing business as CareFirst BlueCross BlueShield (hereafter referred to as "CareFirst") hereby issues this Evidence of Coverage Renewal Amendment (the "Amendment") to:

Harford County Public Schools

(Hereafter referred to as "Group")

The BlueChoice Triple Option Open Access Evidence of Coverage for the contract year July 1, 2017 through June 30, 2018, is renewed without changes to the terms and conditions included therein effective July 1, 2018, except as follows:

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Deleting in its entirety the "Benefit Period" definition from the "Definitions" section of the Evidence of Coverage, and replacing it with the following:

Benefit Period means the period of time during which Covered Services are eligible for payment. The Benefit Period is: July 1st through June 30th.

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All references to "substance abuse" are deleted and replaced with "substance use" throughout the Evidence of Coverage.

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Deleting in its entirety the fourth paragraph of subsection 2.2.C. "Special Enrollment Periods" from the Eligibility and Enrollment section of the Evidence of Coverage and replacing with the following:

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

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Deleting in its entirety subsection 2.2.C.1.c.1)d) from the "Eligibility and Enrollment" section of the Evidence of Coverage.

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Adding the following as subsection "d." to 2.2.C.1., of the "Eligibility and Enrollment" section of the Evidence of Coverage:

d. Applying for special enrollment and effective date of coverage. The Group or CareFirst will allow an employee a period of at least thirty (30) days after an event described above to request enrollment (for the employee or the employee's dependent).

1) Coverage will begin no later than the first day of the first (1st) calendar month beginning after the date the Group or CareFirst receives the request for special enrollment.

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Deleting in its entirety subsection 2.2.C.2.a., from the "Eligibility and Enrollment" section of the Evidence of Coverage and replacing with the following:

2. Special enrollment with respect to certain dependent beneficiaries:

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

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Deleting in its entirety the Subrogation section from the "Coordination of Benefits; Subrogation" section of the Evidence of Coverage and replacing with the following:

Subrogation

1. 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:

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

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

   c. 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. CareFirst will not subrogate a recovery made under Personal Injury Protection policy benefits.

2. 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 Evidence of Coverage, 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 in benefits up to the amount received from or on behalf of the third party. CareFirst will not recover from payments made to the Member under the Member's personal injury protection benefits of their motor vehicle insurance policy. CareFirst will not recover medical expenses from a Subscriber unless the Subscriber or Member recovers for medical expenses in a cause of action or settlement.

3. CareFirst's right of recovery is not subject to reduction for attorney's fees and costs under the "common fund" or any other doctrine. CareFirst will reduce the amount owed by the Member to CareFirst in accordance with applicable law.

4. 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.

For purposes of this provision, “made whole” means that the Member fully recovers all of their damages.

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

6. 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.

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Adding the following to the “How the Plan Works” section of the Evidence of Coverage:

Away From Home Program
If a Member temporarily resides out of the Service Area, the Member may be able to take advantage of the Away From Home Program. This Program may allow a Member who resides out of the Service Area for an extended period of time to utilize the benefits of an affiliated Blue Cross and Blue Shield plan. This Program is not coordination of benefits. **A Member who takes advantage of the Away From Home Program will be subject to the rules, regulations and plan benefits of the affiliated Blue Cross and Blue Shield plan.** If the Member makes a permanent move, he/she does not have to wait until the Open Enrollment Period, determined by the Group to change plans. Members can receive more information about the Away From Home Program by calling the phone number found on the back of the Member identification card or visiting www.carefirst.com.

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All references to “BCBS Global Core” are deleted and replaced with “Blue Cross Blue Shield Global Core” throughout the Evidence of Coverage.

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Adding the following “Ambulance Services” subsection to the Description of Covered Services section of the Evidence of Coverage:

AMBULANCE SERVICES

A. Covered Services

1. Medically Necessary air transportation, surface, and ground ambulance services, as determined by CareFirst.

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Deleting in its entirety, the “Habilitative Services (Dependent child under the age of 19)” paragraph of the Rehabilitative and Habilitative Services subsection of the Description of Covered Services section of the Evidence of Coverage, and replacing it with the following:

Habilitative Services (Dependent child through the end of the month in which the Member turns 19 years old)

Habilitative services are health care services and devices that help a child keep, learn, or improve skills and functioning for daily living.

a. Benefits for Habilitative services will be provided for Members until at least the end of the month in which the Member turns nineteen (19) years old.

b. Benefits include occupational therapy, physical therapy, and speech therapy Habilitative Services for autism or an autism spectrum disorder includes Applied Behavior Analysis services.

Applied Behavior Analysis means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

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Deleting the "Covered Services" subsection of the "Organ and Tissue Transplants" section of the Description of Covered Services of the Evidence of Coverage, and replacing it with the following:

C. Covered Services

1. Medically Necessary, non-Experimental/Investigational solid organ transplant procedures and bone marrow or other non-solid organ transplant procedures, and Related Services.

   Benefits will be provided for high dose chemotherapy/bone marrow or stem cell transplant treatment that is not Experimental/ Investigational as determined by CareFirst.

2. Donor Services, limited to the extent stated above.

3. Clinical evaluation at the organ transplant hospital just prior to the scheduled organ transplant.

4. Immunosuppressant maintenance drugs when prescribed for a covered transplant.

5. Organ transplant procurement benefits for the recipient, as follows:

   a. Health services and supplies used by the surgical team to remove the donor organ.

   b. Travel of a hospital surgical team to and from a hospital (other than the organ transplant hospital) where the organ is to be removed from the donor.

   c. Transport and storage of the organ, at the organ transplant hospital, in accordance with approved practices.

6. Travel for the recipient and companion(s), including lodging expense (and meals), when the organ transplant hospital is over fifty (50) miles from the recipient's home. Travel is limited to transport by a common carrier, including airplane, ambulance services, or personal automobile directly to and from the organ transplant hospital where the organ transplant is performed. In order to receive travel benefits, a companion must be at least eighteen (18) years of age and be the recipient's spouse, parent, legal guardian, brother, sister, or child of the first degree. When the recipient is under eighteen (18) years of age, there may be two companions.

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Deleting the paragraph title "Habilitative Services (Dependent child under the age of 19)" of the "Rehabilitative and Habilitative Services" subsection of the Description of Covered Services section of the Evidence of Coverage, and replacing it with "Habilitative Services (Dependent child through the end of the month in which the Member turns 19 years old)."

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Deleting the "Fees and charges relating to fitness programs…" exclusion in its entirety from the Exclusions section of the Evidence of Coverage and replacing it with the following:

- Fees or charges relating to fitness programs, weight loss or weight control programs, physical conditioning, exercise programs, use of passive or patient-activated exercise equipment other than Medically Necessary and approved pulmonary and/or cardiac rehabilitation programs.

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Adding the following exclusion to the Exclusions section of the Evidence of Coverage:

Ambulance Services

- Except Medically Necessary ambulance services, travel whether or not recommended by a Health Care Provider. Additional limited travel benefits related to an organ transplant may be covered, if stated in the Description of Covered Services.

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Deleting in its entirety, the "Unmarried incapacitated Dependent children/incapacitated Student Dependents" row of the Eligibility table of the Eligibility Schedule of the Evidence of Coverage and replacing it with the following:

Unmarried incapacitated Dependent children/ incapacitated Student Dependents	A Dependent child/Student Dependent covered under this Evidence of Coverage will be eligible for coverage past the Limiting Age if: 1. The Dependent child/Student Dependent is chiefly dependent for support upon the Subscriber or the Subscriber's Dependent spouse; and 2. At the time of reaching the Limiting Age, is incapable of self-support because of mental or physical incapacity that started before the Dependent child/Student Dependent attained the Limiting Age. 3. The Subscriber provides the Group (or CareFirst if the Group so elects) with proof of the Dependent child's/Student Dependent's mental or physical incapacity within thirty-one (31) days after the Dependent child's/Student Dependent's coverage would otherwise terminate. The Group has the right to determine whether the child is and continues to qualify as mentally or physically incapacitated.	**Limiting Age** Not applicable

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Deleting in its entirety, the Special Enrollment Periods table of the Eligibility Schedule of the Evidence of Coverage and replacing it with the following:

SPECIAL ENROLLMENT PERIODS	
Special enrollment for certain individuals who lose coverage (not applicable to retirees, if retirees are eligible for coverage)	The employee must notify the Group, and the Group must notify CareFirst no later than thirty-one (31) days after the exhaustion of the other coverage described or termination of the other coverage as a result of the loss of eligibility for the other coverage described or following the termination of employer contributions toward that other coverage. However, in the case of loss of eligibility for coverage due to the operation of a lifetime limit on all benefits, the Group and CareFirst will allow the employee a period of at least thirty-one (31) days after a claim is denied due to the operation of a lifetime limit on all benefits. A new Subscriber and/or his/her Dependent(s) is effective on the first of the month following acceptance of the enrollment by CareFirst.
Special enrollment for certain dependent beneficiaries	The employee must notify the Group, and the Group must notify CareFirst during the thirty-one (31) day special enrollment period beginning, as follows: In the case of marriage: the date of marriage (or, if Dependent coverage is not generally available at the time of the marriage, a period of thirty-one (31) days after Dependent coverage is made generally available by the Group). In the case of a newly born child: the date of birth (or, if Dependent coverage is not generally available at the time of the birth, a period of thirty-one (31) days after Dependent coverage is made generally available by the Group). In the case of an adopted child: the date of adoption, which is the earlier of the date a judicial decree of adoption is signed; or the assumption of custody, pending adoption, of a prospective adoptive child by a prospective adoptive parent (or, if Dependent coverage is not generally available at the time of the adoption or the placement for adoption, a period of thirty-one (31) days after Dependent coverage is made generally available by the Group).
Special enrollment regarding Medicaid and CHIP termination or eligibility	The employee must notify the Group, and the Group must notify CareFirst no later than sixty (60) days after the date the employee or dependent is terminated as a result of loss of eligibility for coverage under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act. The employee must notify the Group, and the Group must notify CareFirst no later than sixty (60) days after the date the employee or dependent is determined to be eligible for premium assistance, with respect to coverage under this Evidence of Coverage, under Medicaid or a State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan). A new Subscriber and/or his/her dependents are effective on the date coverage terminated as a result of loss of eligibility for coverage under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act; or the date eligible for premium assistance with respect to coverage under this Evidence of Coverage, under Medicaid or a State child health plan.

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Adding the "Mastectomy-Related Services" table to the Schedule of Benefits of the Evidence of Coverage:

Covered Service	CareFirst Payment		
	Level 1	**Level 2**	**Level 3**
Mastectomy-Related Services	Benefits are available to the same extent as benefits provided for other illnesses.		

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Deleting the "Male elective sterilization" row of the Outpatient Surgical Services table of the Schedule of Benefits, and replacing it with the following:

Male elective sterilization	No Deductible required 100% of Allowed Benefit	No Deductible required 100% of Allowed Benefit

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Deleting the "Prescription Drugs" table of the Schedule of Benefits, and replacing it with the following:

Covered Service	CareFirst Payment
Prescription Drugs	
Prescription Drugs	**Limitations** Benefits for Pharmacy-dispensed Prescription Drugs, intended for outpatient use, are stated in the Prescription Drug Benefits Rider; otherwise, benefits for Prescription Drugs, intended for outpatient use, are limited to injectable Prescription Drugs that require administration by a Health Care Provider. Benefits are also available for injectable Prescription Drug contraceptives and contraceptive devices approved by the FDA for use as a contraceptive, prescribed by a Health Care Provider, and dispensed in the office of a Health Care Provider.
Prescription Drugs (except Prescription Drug contraceptives and contraceptive devices dispensed in the office of a Health Care Provider)	No Deductible required 100% of Allowed Benefit
Prescription Drug contraceptives and contraceptive devices dispensed in the office of a Health Care Provider)	No Deductible required 100% of Allowed Benefit

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Adding the following definitions to the Definitions section of the "TOTAL CARE AND COST IMPROVEMENT, PATIENT-CENTERED MEDICAL HOME, HEALTH PROMOTION AND WELLNESS PROGRAM, AND DISEASE MANAGEMENT" Addendum attached to the Evidence of Coverage:

Enhanced Monitoring Program (EMP) means the CareFirst program for Members with a chronic condition or disease for which medical equipment and monitoring services are provided to help the Member manage the chronic condition or disease.

Expert Consultation Program (ECP) means the CareFirst Program for Members with a complex or rare condition or multiple conditions or diseases for which the course of treatment requires unique expertise.

Adding the following sections to the Description of Covered Service of the Addendum and renumbering all subsequent subsections, if any:

C. **Enhanced Monitoring Program**

Benefits for medical equipment and monitoring services will be provided to a Member, without an active plan of care, who qualifies under the EMP as determined by CareFirst.

CareFirst payment for EMP in-network Covered Services is 100% of the Allowed Benefit. EMP benefits are not subject to the Deductible, if a Deductible is stated in the Schedule of Benefits of the Evidence of Coverage. There are no out-of-network EMP benefits available.

D. **Expert Consultation Program**

Benefits for review of a Member's medical records by a team of specialists will be provided to a Member, without an active plan of care, who qualifies under the ECP as determined by CareFirst. The review of the Member's medical records will be done in accordance with the ECP.

CareFirst payment for ECP in-network Covered Services is 100% of the Allowed Benefit. ECP benefits are not subject to the Deductible, if a Deductible is stated in the Schedule of Benefits of the Evidence of Coverage. There are no out-of-network ECP benefits available.

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Deleting in its entirety, section K.1., and K.2., of the Claims Procedures section of the Evidence of Coverage, and replacing it with the following:

K. EXTERNAL REVIEW PROCESS

1. When filing a request for an External Review, the Claimant will be required to authorize the release of any medical records of the Claimant that may be required to be reviewed for the purpose of reaching a decision on the External Review.

2. If a Claimant is in need of assistance, they may contact the appropriate state agency as follows:

Health Education and Advocacy Unit
Consumer Protection Division
Office of the Maryland Attorney General
200 St. Paul Place, 16th Floor
Baltimore, MD 21202
(Phone: 410-528-1840 or 1-877-261-8807
Fax: 410-576-6571
http://www.marylandattorneygeneral.gov/Pages/CPD/heau

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This amendment is issued to be attached to the Evidence of Coverage. All remaining terms and conditions of the Evidence of Coverage shall remain in full force and effect. Where the provisions of this amendment and the Evidence of Coverage vary, the provisions of this amendment will prevail over the Evidence of Coverage. Where the provisions of this amendment and a previously effective amendment vary, the provisions of this amendment will prevail.