Group Hospitalization and Medical Services, Inc.
doing business as
CareFirst BlueCross BlueShield (CareFirst)
840 First Street, NE
Washington, DC 20065
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A not-for-profit health service plan

An independent licensee of the Blue Cross and Blue Shield Association

NOTICE TO EMPLOYER OF COVERAGE UNDER SUCCEEDING POLICY

You are hereby notified of certain policy provisions that limit or exclude coverage in your proposed CareFirst group health benefit plan (the "Certificate of Coverage"). This notice is provided prior to entering into the Certificate of Coverage, in accordance with Section 15-415 of the Maryland Insurance Article.

You are urged to read the Certificate of Coverage whose terms will govern your benefits.

I. Exclusions from Coverage.

The following provisions limit or exclude benefits under the Certificate of Coverage.

- Services or supplies that are determined by CareFirst to be not Medically Necessary, as defined.

  Medical Necessity or Medically Necessary means health care services or supplies that a Provider, exercising prudent clinical judgment, renders to, or recommends for, a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms. These health care services 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 Provider; and (d) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results in the diagnosis or treatment of that patient's illness, injury or disease. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations and the views of Providers practicing in relevant clinical areas and any other relevant factors.

  Payment for inpatient ancillary services may not be denied solely based on the fact that the denial of the hospitalization day was appropriate. A denial of inpatient ancillary services must be based on the Medical Necessity of the specific ancillary service. In determining the Medical Necessity of an ancillary service performed on a denied hospitalization day, consideration must be given to the necessity of providing the ancillary service in the acute setting for each day in question.

- Services performed or prescribed under the direction of a person who is not an appropriately licensed health care practitioner.

- Services that are beyond the scope of practice of the health care practitioner performing the service.

- Services to the extent they are covered by any governmental unit, except for veterans in Veteran's Administration or armed forces facilities for services received for which the recipient is liable.

- Services or supplies for which Members are not legally, or as a customary practice, required to pay in the absence of a health benefit plan.

- The purchase, examination, or fitting of eyeglasses or contact lenses, except for aphakic patients and soft or rigid gas permeable lenses or sclera shells intended for use in the treatment of a disease or injury.

- Personal Care services and Domiciliary Care services, as defined.

  A. **Personal Care** means a service that an individual normally would perform personally, but for which the individual needs help from another because of advanced age, infirmity, or physical or mental limitation.
  Personal Care includes:

    1. Help in walking;
    2. Help in getting in and out of bed;
    3. Help in bathing;
    4. Help in dressing;
    5. Help in feeding; and
    6. General supervision and help in daily living.

  B. **Domiciliary Care** means services that are provided to aged or disabled individuals in a protective, institutional or home-type environment.
  Domiciliary Care includes:

    1. shelter;
    2. housekeeping services;
    3. board;
    4. facilities and resources for daily living; and
    5. personal surveillance or direction in the activities of daily living.

- Services rendered by a health care practitioner who is the Member's spouse, mother, father, daughter, son, brother or sister.

- Experimental Services, as defined.

  Experimental Services means services that are not recognized as efficacious as that term is defined in the edition of the Institute of Medicine Report on Assessing Medical Technologies that is current when the care is rendered. Experimental Services do not include controlled clinical trials.

- Health care practitioner, hospital, or clinical services related to radial keratotomy, myopic keratomileusis, and surgery which involves corneal tissue for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error.

- In vitro fertilization, ovum transplants and gamete intra-fallopian tube transfer, zygote intra-fallopian transfer, or cryogenic or other preservation techniques used in these or similar procedures.

- Services to reverse a voluntary sterilization procedure.

- Services for sterilization or reverse sterilization for a dependent minor.

- Services incurred before the effective date of the Member's coverage under the Certificate of Coverage or Group Contract.

- Services incurred after the Member's termination of coverage, including any extension of benefits.

- Surgery or related services for cosmetic purposes to improve appearance, but not to restore bodily function or correct deformity resulting from disease, trauma, congenital, or developmental anomalies.

- Services for injuries or diseases related to the Member's job to the extent the Member is required to be covered by a workers' compensation law.

- Services 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.

- Personal hygiene and convenience items, including, but not limited to, air conditioners, humidifiers, or physical fitness equipment.

- Charges for telephone consultations, failure to keep a scheduled visit, or completion of any form.

- Inpatient admissions primarily for diagnostic studies, unless authorized by CareFirst.

- The purchase, examination, or fitting of hearing aids and supplies, and tinnitus maskers, except as provided under the Certificate of Coverage.

- Except for covered ambulance services, travel, whether or not recommended by a health care practitioner.

- Except for emergency services, services received while the Member is outside the United States.

- Immunizations related to foreign travel.

- Unless otherwise specified under the Certificate of Coverage, dental work or treatment which includes hospital or professional care in connection with:

  A. The operation or treatment for the fitting or wearing of dentures;

  B. Orthodontic care or malocclusion;

  C. Operations on or for treatment of or to the teeth or supporting tissues of the teeth, except for removal of tumors and cysts or treatment of injury to natural teeth due to an accident if the treatment is received within six months of the accident; and

  D. Dental implants.

- Accidents occurring while and as a result of chewing.

- Routine foot care, including the paring or removing of corns and calluses, or trimming of nails, unless these services are determined to be Medically Necessary.

- Arch support, orthotic devices, in-shoe supports, orthopedic shoes, elastic supports or exams for their prescription or fitting unless these services or supplies are determined to be Medically Necessary.

- Inpatient admissions primarily for physical therapy, unless authorized by CareFirst.

- Treatment leading to or in connection with transsexualism, or sex changes or modifications, including, but not limited to surgery.

- Treatment of sexual dysfunction not related to organic disease.

- Services or supplies that duplicate benefits provided under federal, State, or local laws, regulations, or programs.

- Organ transplants except those included as covered as stated in the Certificate of Coverage.

- Non-human organs and their implantation.
- Non-replacement fees for blood and blood products.
- Lifestyle improvements, including nutrition counseling, or physical fitness programs unless included in the Certificate of Coverage.
- Wigs or cranial prosthesis.
- Weekend admission charges, except for emergencies and maternity, unless authorized by CareFirst.
- Outpatient orthomolecular therapy, including nutrients, vitamins, and food supplements.
- Temporomandibular joint syndrome (TMJ) treatment and treatment for craniomandibular pain syndrome (CPS), except for surgical services for TMJ and CPS, if Medically Necessary and if there is a clearly demonstrable radiographic evidence of joint abnormality due to a disease or injury.
- Services 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.
- Services for conditions that State or local laws, regulation, ordinances, or similar provisions require to be provided in a public institution.
- Services for, or related to, the removal of an organ from a Member for purposes of transplantation into another person unless the transplant recipient is covered under this Certificate of Coverage or Group Contract and is undergoing a covered transplant, and the services are not payable by another health plan.
- Physical examinations required for obtaining or continuing employment, insurance, or government licensing.
- Non-medical ancillary services such as vocational rehabilitation, employment counseling, or educational therapy.
- Private hospital room, unless authorized by CareFirst as Medically Necessary.
- Private duty nursing unless authorized by CareFirst.
- Treatment for mental health or substance abuse not authorized by CareFirst’s Mental Health Management Program; or a mental health or substance abuse condition determined by CareFirst’s Mental Health Management Program to be untreatable.
- Services related to smoking cessation.
- Medical or surgical treatment or regimen for reducing or controlling weight, unless otherwise specified in the covered services.

II. Pre-existing Conditions Exclusion Period

A Member's coverage under the Certificate of Coverage may be subject to a pre-existing condition exclusion period. This pre-existing condition exclusion period will apply if a Member fails to enroll within certain time frames stated in the Certificate of Coverage. A pre-existing condition means a condition (whether physical or mental, and regardless of the cause of the condition) for which medical advice, diagnosis, care or treatment was recommended or received by a health care practitioner within a 6-month period ending on the Member's enrollment date. If a pre-existing condition exclusion period applies, CareFirst will not provide benefits to a Member for any services in connection with a Member's pre-existing condition for a specified time following the Member's enrollment date as stated in the Certificate of Coverage. A pre-existing condition exclusion period does not apply to Members who are under the age of 19 and will not apply to services furnished to any Member for pregnancy or newborns. A pre-existing condition exclusion period may be reduced, or eliminated, if the Member produces appropriate evidence of prior creditable coverage.