State: *District of Columbia* ***Filing Company:*** *Group Hospitalization and Medical Services, Inc.*
TOI/Sub-TOI: *HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.003A Large Group Only - PPO*
Product Name: *GHMSI 2017 LG AMEND*
Project Name/Number: *GHMSI 2017 LG AMEND/DC/CF/2017 LG AMEND (1/17)*

Filing at a Glance

Company:	Group Hospitalization and Medical Services, Inc.
Product Name:	GHMSI 2017 LG AMEND
State:	District of Columbia
TOI:	HOrg02G Group Health Organizations - Health Maintenance (HMO)
Sub-TOI:	HOrg02G.003A Large Group Only - PPO
Filing Type:	Form
Date Submitted:	11/17/2016
SERFF Tr Num:	CFBC-130812210
SERFF Status:	Assigned
State Tr Num:	
State Status:	
Co Tr Num:	DC/CF/2017 LG AMEND (1/17)
Implementation Date Requested:	On Approval
Author(s):	Rachel Peters, Gina Harrison
Reviewer(s):	Colin Johnson (primary)
Disposition Date:	
Disposition Status:	
Implementation Date:	

State: *District of Columbia* **Filing Company:** *Group Hospitalization and Medical Services, Inc.*
TOI/Sub-TOI: *HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.003A Large Group Only - PPO*
Product Name: *GHMSI 2017 LG AMEND*
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General Information

Project Name: GHMSI 2017 LG AMEND
Project Number: DC/CF/2017 LG AMEND (1/17)
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Group Market Type:
Filing Status Changed: 11/17/2016
State Status Changed:
Created By: Rachel Peters
Corresponding Filing Tracking Number:

Status of Filing in Domicile:
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Group
Group Market Size: Small and Large
Overall Rate Impact:
Deemer Date:
Submitted By: Rachel Peters

PPACA: Not PPACA-Related

PPACA Notes: null

Include Exchange Intentions: No

Filing Description:

Attached for your review and approval is a copy of the above-referenced form in its final version. The purpose of this filing is to request approval for the attached form that contain updates to forms previously approved by the Department of Insurance, Securities and Banking for existing products (as described below) issued by CareFirst BlueChoice in the large group market. This includes Point-of-Service products where the in-network benefit are underwritten by CareFirst BlueChoice and out-of-network benefits are underwritten by Group Hospitalization and Medical Services, Inc. These updates are based on internal business decisions to improve operations and customer service.

2017 Amendment (Form No. DC/CF/2017 LG AMEND (1/17)

The purpose of this amendment is based on internal business decisions to improve operations and customer service. The updates are also made to ensure that they are compliant with the District of Columbia Department of Insurance, Securities and Banking requirements and legislation. We have made the following revisions:

•We have revised the definition of “Allowed Benefit” within the Evidence of Coverage,

•We have replaced the definition of “Prior Authorization List” with the definition of “Prescription Guidelines” and changed references to “Prior Authorization List” to “Prescription Guidelines”. We have changed the references to “Preferred Preventive Drug” to “Preventive Drug” as well as the reference to “Preferred Preventive Drug List” to “Preventive Drug List”. The updates are within the Evidence of Coverage.

•We have revised the Eligibility of Children provision in the Evidence of Coverage to clarify the definition of Dependent Child eligibility.
•
•We have revised the Proof of Loss provision in the Evidence of Coverage to be consistent across products and jurisdiction.

•We have revised the Member Privacy provision in the Evidence of Coverage.

•We have revised the provision on Service Area in the Evidence of Coverage.

State: District of Columbia **Filing Company:** Group Hospitalization and Medical Services, Inc.
TOI/Sub-TOI: HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.003A Large Group Only - PPO
Product Name: GHMSI 2017 LG AMEND
Project Name/Number: GHMSI 2017 LG AMEND/DC/CF/2017 LG AMEND (1/17)

•We have added a statement in the Prescription Drug Benefits Rider stating that a member may obtain up to a twelve month supply of contraceptives at one time.

The forms may be included on our website at www.carefirst.com. This filing does not affect existing rates. The Readability Compliance Certification is also included with these forms. The forms will attach to an evidence of coverage with a Flesch Reading Ease score of 40 or more.

Company and Contact

Filing Contact Information

Rachel Peters, Senior Contract Specialist
840 First Street NE
Washington, DC 20065

rachel.peters@carefirst.com
202-680-5235 [Phone]
202-680-5235 [FAX]

Filing Company Information

Group Hospitalization and Medical Services, Inc.
840 First Street NE
Washington, DC 20065
(202) 479-8000 ext. [Phone]

CoCode: 53007
Group Code:
Group Name:
FEIN Number: 53-0078070

State of Domicile: District of Columbia
Company Type:
State ID Number:

Filing Fees

Fee Required? No
Retaliatory? No
Fee Explanation:

SERFF Tracking #:	*CFBC-130812210*	***State Tracking #:***		***Company Tracking #:***	*DC/CF/2017 LG AMEND (1/17)*

State:	*District of Columbia*	***Filing Company:***	*Group Hospitalization and Medical Services, Inc.*
TOI/Sub-TOI:	*HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.003A Large Group Only - PPO*		
Product Name:	*GHMSI 2017 LG AMEND*		
Project Name/Number:	*GHMSI 2017 LG AMEND/DC/CF/2017 LG AMEND (1/17)*		

Form Schedule

Lead Form Number: DC/CF/2017 LG AMEND (1/17)

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		2017 AMENDMENT	DC/CF/2017 LG AMEND (1/17)	CERA	Initial			DC CF 2017 LG AMEND (1-17).pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

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

2017 AMENDMENT

This amendment is effective [_____]. If no date is shown, this amendment is effective on the effective date or renewal date of the Evidence of Coverage to which this amendment is attached.

TABLE OF CONTENTS

The Evidence of Coverage is amended as follows:

SECTION A - DEFINITIONS

1. The definition of "Allowed Benefit" in Section 1 of the [Out-of-Network] Evidence of Coverage is deleted and replaced with the following:

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 that 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.

Available variable for bracketed term [Preferred] is and [Participating]. Variables provide flexibility for the network provider name. Use of variables will depend on which market product contract that the amendment is used.

Available variables for bracketed term [Non-Preferred] are [Out-of-Network] and [Non-Participating]. Variables provide flexibility for a non-participating provider name. Use of variables will depend on which market product contract that the amendment is used.

[2. The [following] definition of "Prescription Drugs" [in Section 1 of the [Out-of-Network] Evidence of Coverage is deleted and replaced with the following][is added to Section 1, Definitions]:

The variables in the following statements will be used based on whether the amended provision is being deleted and replaced or added.

- *The [following] definition of "Prescription Drugs" [in Section 1 of the Evidence of Coverage is deleted and replaced with the following][is added to Section 1, Definitions]:*
- *The [following] definition of "Prior Authorization List" [in Section 1, Definitions, of the Evidence of Coverage is deleted and replaced with the following][is added to Section 1, Definitions]:*

Provisions 4 and 5 may be removed from the amendment if the terms are already included in the Evidence of Coverage the amendment is attached.

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 bio-equivalent Prescription Drug; or

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

3. All references to "Prior Authorization List" in the [Out-of--Network] Evidence of Coverage are replaced with "Prescription Guidelines".

The [following] definition [of "Prior Authorization List"] [in Section 1, Definitions, of the [Out-of-Network] Evidence of Coverage is deleted and replaced with the following][is added to Section 1, Definitions]:

The variables in the following statements will be used based on whether the amended provision is being deleted and replaced or added.

- *The [following] definition of "Prescription Drugs" [in Section 1 of the [Out-of-Network] Evidence of Coverage is deleted and replaced with the following][is added to Section 1, Definitions]:*

- *The [following] definition of "Prior Authorization List" [in Section 1, Definitions, of the [Out-of-Network] Evidence of Coverage is deleted and replaced with the following][is added to Section 1, Definitions]:*

Provisions 4 and 5 may be removed from the amendment if the terms are already included in the Evidence of Coverage the amendment is attached.

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 CareFirst has placed on certain drugs. A copy of the Prescription Guidelines is available to the Member upon request.

4. [All references to "Preferred Preventive Drug" in the [Out-of-Network] Evidence of Coverage are replaced with "Preventive Drug".]

[The following definition of "Preventive Drug" is added to Section 1, Definitions]:

[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.]

The variables in the following statements will be used based on whether the amended provision is being deleted and replaced or added.

- *The [following] definition of "Prescription Drugs" [in Section 1 of the [Out-of-Network] Evidence of Coverage is deleted and replaced with the following][is added to Section 1, Definitions]:*
- *The [following] definition of "Prior Authorization List" [in Section 1, Definitions, of the [Out-of-Network] Evidence of Coverage is deleted and replaced with the following][is added to Section 1, Definitions]:*

5. [All references to "Preferred Preventive Drug List" in the [Out-of-Network] Evidence of Coverage are replaced with "Preventive Drug List".]

[The following definition of "Preventive Drug List" is added to Section 1, Definitions:]

[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 without notice to Members. A copy of the Preventive Drug List is available to the Member upon request.]

The variables in the following statements will be used based on whether the amended provision is being deleted and replaced or added.

- *The [following] definition of "Prescription Drugs" [in Section 1 of the [Out-of-Network] Evidence of Coverage is deleted and replaced with the following][is added to Section 1, Definitions]:*
- *The [following] definition of "Prior Authorization List" [in Section 1, Definitions, of the [Out-of-Network] Evidence of Coverage is deleted and replaced with the following][is added to Section 1, Definitions]:*]

SECTION B – ELIGIBILITY OF DEPENDENT CHILDREN

All provisions of the Evidence of Coverage that define or describe Eligibility of Dependent Children are revised as follows:

A Dependent Child means an individual who:

A. Is:

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

2. A child placed with the Subscriber or the Subscriber's covered Spouse for legal Adoption;

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

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, and

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

SECTION C - PROOF OF LOSS

Section [XX], Proof of Loss, of the [Out-of-Network] Evidence of Coverage is deleted and replaced with the following:

[XX]. Proof of Loss. For Covered Services, [Covered Dental Services] [or Covered Vision Services] provided by Non-[Preferred; Participating] Providers, [Non-Participating Dentists] or [Non-Contracting Vision Providers], 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. 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 by any agency of the federal, state or local government that has the statutory authority to submit claims beyond the time limits established under this Evidence of Coverage. These claims must be submitted to CareFirst before the filing deadline established by the applicable statute on claims forms that provide all of the information CareFirst deems necessary to process the claims. CareFirst provides forms for this purpose.

SECTION D- CONVERSION PRIVILEGE

Section 5, Conversion Privilege, of the [Out-of-Network] Evidence of Coverage is deleted in its entirety.

SECTION E - MEMBER PRIVACY

Section [XX], Member Privacy, of the [Out-of-Network] Evidence of Coverage deleted and replaced with the following:

[XX.] 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 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.

SECTION F - CREDIT MONITORING

The following is added to the General Provisions section of the [Out-of-Network] Evidence of Coverage:

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].

[SECTION G – EXCLUSIONS AND LIMITATIONS

Section [10; 12].1[JJ; FF; GG; NN] of the [Out-of-Network] Description of Covered Services is deleted and replaced with:

MM. Services required solely for administrative purposes, including but not limited to employment, insurance, foreign travel, school, camp admissions or participation in sports activities.]

[SECTION H – PRESCRIPTION DRUGS

The following is added to the Prescription Drug Benefits Rider:

A Member may obtain up to a twelve (12) month supply of contraceptives at one time.]

This amendment is issued to be attached to the [Out-of-Network] Evidence of Coverage. This amendment does not change the terms and conditions of the [Out-of-Network] Evidence of Coverage, unless specifically stated herein.

Group Hospitalization and Medical Services, Inc.

[Signature]

_____

[Name]
[Title]

SERFF Tracking #:	*CFBC-130812210*	***State Tracking #:***		***Company Tracking #:***	*DC/CF/2017 LG AMEND (1/17)*

State:	*District of Columbia*	***Filing Company:***	*Group Hospitalization and Medical Services, Inc.*
TOI/Sub-TOI:	*HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.003A Large Group Only - PPO*		
Product Name:	*GHMSI 2017 LG AMEND*		
Project Name/Number:	*GHMSI 2017 LG AMEND/DC/CF/2017 LG AMEND (1/17)*		

Supporting Document Schedules

Satisfied - Item:	Submission Letter
Comments:	
Attachment(s):	DC CF 2017 LG AMEND (1-17) Submission Letter.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Readability Certification
Comments:	
Attachment(s):	DC CF 2017 LG AMEND (1-17) Readability Cert.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Explanation of Variations
Comments:	
Attachment(s):	DC CF 2017 LG AMEND (1-17) eov.pdf
Item Status:	
Status Date:	

CareFirst BlueCross BlueShield
840 First Street, NE
Washington, DC 20065
www.carefirst.com

VIA SERFF
November 17, 2016

Stephen C. Taylor, Commissioner
Department of Insurance, Securities and Banking
810 First Street, NE
Suite 701
Washington, DC 20002

RE: Group Hospitalization and Medical Services, Inc. doing business as CareFirst BlueCross BlueShield (CareFirst)
NAIC Number: 53007
Form Number: DC/CF/2017 LG AMEND (1/17)

Dear Commissioner Taylor:

Attached for your review and approval is a copy of the above-referenced form in its final version. The purpose of this filing is to request approval for the attached form that contain updates to forms previously approved by the Department of Insurance, Securities and Banking for existing products (as described below) issued by CareFirst BlueChoice in the large group market. This includes Point-of-Service products where the in-network benefit are underwritten by CareFirst BlueChoice and out-of-network benefits are underwritten by Group Hospitalization and Medical Services, Inc. These updates are based on internal business decisions to improve operations and customer service.

2017 Amendment (Form No. DC/CF/2017 LG AMEND (1/17)

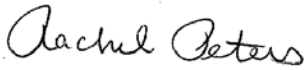
The purpose of this amendment is based on internal business decisions to improve operations and customer service. The updates are also made to ensure that they are compliant with the District of Columbia Department of Insurance, Securities and Banking requirements and legislation. We have made the following revisions:

- We have revised the definition of "Allowed Benefit" within the Evidence of Coverage,
- We have replaced the definition of "Prior Authorization List" with the definition of "Prescription Guidelines" and changed references to "Prior Authorization List" to "Prescription Guidelines". We have changed the references to "Preferred Preventive Drug" to "Preventive Drug" as well as the reference to "Preferred Preventive Drug List" to "Preventive Drug List". The updates are within the Evidence of Coverage.
- We have revised the Eligibility of Children provision in the Evidence of Coverage to clarify the definition of Dependent Child eligibility.
-
- We have revised the Proof of Loss provision in the Evidence of Coverage to be consistent across products and jurisdiction.
- We have revised the Member Privacy provision in the Evidence of Coverage.
- We have revised the provision on Service Area in the Evidence of Coverage.
- We have added a statement in the Prescription Drug Benefits Rider stating that a member may obtain up to a twelve month supply of contraceptives at one time.

The forms may be included on our website at www.carefirst.com. This filing does not affect existing rates. The Readability Compliance Certification is also included with these forms. The forms will attach to an evidence of coverage with a Flesch Reading Ease score of 40 or more.

We appreciate your consideration of this matter and look forward to your acknowledgement and approval of these forms. If you have any questions, please contact Rachel Peters at (202) 680-5235 or via e-mail at Rachel.Peters@carefirst.com.

Sincerely,



Rachel Peters
Senior Contract Specialist
Benefit Contract Management

cc: Gina Harrison
Ryan Mihalic

READABILITY COMPLIANCE CERTIFICATION

NAME & ADDRESS OF INSURER: Group Hospitalization and Medical Services, Inc.
840 First Street, NE, Washington, DC 20065
202-479-8000

I hereby certify that the policy form number listed below will attach to an evidence of coverage with a Flesch reading ease score above 40.0.

DC/CF/2017 LG AMEND (1/17)

Group Hospitalization and Medical Services, Inc. has reviewed the enclosed policy form and certifies that, to the best of its knowledge and belief, the form submitted is consistent and complies with the requirements of the District of Columbia Code, particularly §31-4725 and §31-4726(b)(2) of the District of Columbia Code.

Signed by Officer of the Insurer
Randolph S. Sergent
Vice President and Deputy General Counsel

11/17/2016
Date

Note: If any variation is deleted, the remaining provisions will be renumbered/re-lettered accordingly and appropriate adjustment made to alignment. Bracketed provision references will also be renumbered.

The bracketed text in the opening paragraph allows CareFirst to use a specific date or the effective/renewal date of the [Out-of-Network] Evidence of Coverage.

The variable text [Out-of-Network] that appears throughout the form will be used when the form is used for our dual offering for which In-Network benefits are underwritten by CareFirst BlueChoice Inc., and Out-of-Network benefits are underwritten by Group Hospitalization and Medical Services, Inc.

Bracketed section references in the form will be included or deleted, as appropriate, to coordinate the provision in the amendment to the appropriate provision in the core form, as that core form is used for a particular product.

SECTION A - DEFINITIONS

Allowed Benefit:
Available variable for bracketed term [Preferred] is and [Participating]. Variables provide flexibility for the network provider name. Use of variables will depend on which market product contract that the amendment is used.

Available variables for bracketed term [Non-Preferred] are [Out-of-Network] and [Non-Participating]. Variables provide flexibility for a non-participating provider name. Use of variables will depend on which market product contract that the amendment is used.

Prescription Drug:

The variables in the following statements will be used based on whether the amended provision is being deleted and replaced or added.

- ***The [following] definition of "Prescription Drugs" [in Section 1 of the [In-Network] Evidence of Coverage is deleted and replaced with the following][is added to Section 1, Definitions]:***

- ***The [following] definition of "Prior Authorization List" [in Section 1, Definitions, of the [In-Network] Evidence of Coverage is deleted and replaced with the following][is added to Section 1, Definitions]:***

Provisions 4 and 5 may be removed from the amendment if the terms are already included in the Evidence of Coverage the amendment is attached.

SECTION C - PROOF OF LOSS

Bracketed section references in the form will be included or deleted, as appropriate, to coordinate the provision in the amendment to the appropriate provision in the core form, as that core form is used for a particular product.

SECTION E - MEMBER PRIVACY

Bracketed section references in the form will be included or deleted, as appropriate, to coordinate the provision in the amendment to the appropriate provision in the core form, as that core form is used for a particular product.

SECTION F- CREDIT MONITORING
The name of the credit monitoring provider, phone number and website address are bracketed to allow for changes if the contact information changes in the future.

SECTION G - EXCLUSIONS AND LIMITATIONS

The entire section is bracketed and will be omitted when the amendment attaches to an Evidence of Coverage that already contains this provision. Bracketed section references in the form will be included or deleted, as appropriate, to coordinate the provision in the amendment to the appropriate provision in the core form, as that core form is used for a particular product.

SECTION H – PRESCRIPTION DRUGS

The entire section is bracketed and will be omitted when the amendment attaches to an Evidence of Coverage that does not include a Prescription Drug Benefits Rider.

In the signature block at the bottom of the form, the variations will be for the signature, name, and title of the CareFirst officer.