FINAL
August 12, 2020

SUMMARY PLAN DESCRIPTION

for the

CareFirst Retiree PPO Medical Plan under the

Washington Gas Light Company Retiree Medical Plan

January 1, 2020

TABLE OF CONTENTS

IMPORTANT INFORMATION 2
STATEMENT OF ERISA RIGHTS 8
HOW THE RETIREE PPO PROGRAM WORKS 10
GENERAL FEATURES OF THE MEDICAL BENEFIT 13
COMMONLY ASKED QUESTIONS AND ANSWERS 16
ELIGIBILITY AND ENROLLMENT 17
TERMINATION OF COVERAGE 23
CONTINUATION COVERAGE RIGHTS UNDER COBRA 26
MULTIPLE COVERAGES 35
MEDICAL BENEFIT CLAIMS PROCEDURES 40
GENERAL PLAN PROVISIONS 62
DEFINITIONS 67
INTER-PLAN ARRANGEMENTS 74
UTILIZATION MANAGEMENT REQUIREMENTS 80
DESCRIPTION OF COVERED MEDICAL SERVICES 84
EXCLUSIONS AND LIMITATIONS 122
SCHEDULE OF MEDICAL BENEFITS 128
PRESCRIPTION DRUG BENEFITS 144
APPENDIX A 168

SUMMARY PLAN DESCRIPTION
As of January 1, 2020

Washington Gas Light Company ("Washington Gas") has established the Washington Gas Light Company CareFirst Retiree PPO Medical Plan (the "Plan") to provide medical benefits to eligible Retirees of Washington Gas and affiliated Employers that have adopted the Plan with the approval of Washington Gas. The Plan is a benefit option under the Washington Gas Light Company Retiree Medical Plan. Unless otherwise indicated, Washington Gas shall act for, and on behalf of, each affiliated Employer that is participating in the Plan.

This document serves as the Summary Plan Description for the CareFirst Retiree PPO Medical Plan, which is administered by CareFirst BlueCross BlueShield, and for the Prescription Drug Benefits program, which is administered by CVS Caremark. As such, this document provides a summary of benefits available to eligible Retirees of Washington Gas and participating Employers and is intended to comply with the summary plan description requirements under the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

The terms and conditions of the Plan are set forth in this Summary Plan Description and the formal Plan Document. This Summary Plan Description is incorporated by reference into the formal Plan Document and, together, they constitute the written instruments under which the Plan is established and maintained. An amendment to one of these documents constitutes an amendment to the Plan.

While every attempt has been made to make this information as accurate and complete as possible, if this Summary Plan Description differs from a provision contained in the formal Plan Document, the Plan Document controls.

Unless otherwise stated, the benefits described in this document are those available to eligible Retirees as of January 1, 2020. For ERISA Summary Plan Description purposes, this description supersedes all other previous versions of summary plan descriptions for the CareFirst Retiree PPO Medical Plan and the CVS Caremark Prescription Drug Benefits program.

Washington Gas reserves the right to unilaterally, at any time and at its discretion, amend, supplement, modify or eliminate any or all of the benefits described in this document. This document does not create a contract or a guarantee of employment between you and your Employer.

SUMMARY PLAN DESCRIPTION
As of January 1, 2020

IMPORTANT INFORMATION

Washington Gas has entered into Administrative Services Contracts with CareFirst BlueCross BlueShield (CareFirst) and CVS Caremark. Under the terms of these contracts, benefits are paid out of the Post-Retirement VEBAs (described below). Should either the Post-Retirement VEBAs or your Employer be unable to pay for your medical expenses or prescription drug expenses, you may not seek payment from CareFirst or CVS Caremark or another Employer.

Plan Name:	CareFirst Retiree PPO Medical Plan, which is a benefit option under the Washington Gas Light Company Retiree Medical Plan.
Plan Number:	540
Type of Plan:	Welfare benefit plan providing medical and prescription drug benefits. The information in this Summary Plan Description describes the retiree medical PPO benefit that is administered by CareFirst and the prescription drug benefit that is administered by CVS Caremark. The Washington Gas Light Company Retiree Medical Plan also provides medical benefits under the Kaiser HMO, which is an insured plan provided by Kaiser Permanente (this option is frozen to new enrollees). Information on this other benefit option (or a copy of the applicable summary plan description) is available from the Plan Administrator at the address and phone number listed below.
Plan Year:	The Plan operates on a calendar year basis from January 1 – December 31.
Employer Information/Plan Sponsor:	Washington Gas Light Company 6801 Industrial Road Springfield, VA 22151 (703) 750-1000 EIN – 53-0162882 The company’s corporate and administrative

	offices are located at: 1000 Maine Avenue SW Washington, DC 20024
Affiliated Employers Adopting the Plan ("Employers"):	Hampshire Gas Company 114 Hampshire Gas Drive Romney, WV 26757 EIN – 52-0787226 WGL Energy Services, Inc.* 8614 Westwood Center Drive, Suite 1200 Vienna, VA 22182 EIN 52-1542887 WGL Energy Systems, Inc.* 8614 Westwood Center Drive, Suite 1200 Vienna, VA 22182 EIN 62-1366463 WGL Midstream, Inc. 1000 Maine Avenue SW Washington, DC 20024 *WGL Energy Services, Inc. and WGL Energy Systems, Inc. are Employers solely for the purpose of covering certain former employees of Washington Gas Light Company and Hampshire Gas Company that worked continuously for Washington Gas Light Company and/or Hampshire Gas Company immediately prior to transferring employment to WGL Energy Services, Inc. or WGL Energy Systems, Inc., where such transfer occurred on or after January 1, 2016.
Plan Contact:	Director – Benefits and Wellness Washington Gas Light Company 6801 Industrial Road Springfield, VA 22151 Attention: Joseph Esposito (703) 750-4582

SUMMARY PLAN DESCRIPTION
As of January 1, 2020

HR Service Center:

HR Service Center
Washington Gas
6801 Industrial Road
Springfield, VA 22151
(703) 750-7779

COBRA Administrator:

WageWorks, Inc.
www.wageworks.com
Phone: (877) 502-6272

Address for COBRA Elections:
PO Box 14055
Lexington, KY 40512-4055
Fax: (877) 220-3249

Address for COBRA Premium Payments:
1155 Reliable Parkway
Chicago, IL 60686-0011

Plan Administrator:

Washington Gas Light Company Benefits Administration Committee
Attention: Director, Benefits and Wellness
6801 Industrial Road
Springfield, VA 22151
(703) 750-4582

Within the meaning of ERISA, the Washington Gas Light Company Benefits Administration Committee or its designee is the Plan Administrator and, as such, is responsible for satisfying certain legal requirements under ERISA with respect to the Plan.

Type of Administration:

The administration of the Plan is under the supervision of the Plan Administrator. The Plan Administrator may delegate in writing responsibility for the operation and administration of the Plan.

Medical claims are processed through a contract with CareFirst BlueCross Blue Shield. Prescription drug claims are processed through a contract with

CVS Caremark.

Claims Administrator:

Medical Claims:
CareFirst Blue Cross Blue Shield (CareFirst)
P.O. Box 45114
Lexington, KY 40512-4114(800) 628-8549

Prescription Drug Claims:
CVS Caremark (PCS)
P.O. Box 52084
Phoenix, AZ 85072-2084
(800) 966-5772

Appeals Manager/Fiduciary:

CareFirst Blue Cross Blue Shield is the named fiduciary with responsibility for deciding appeals for medical benefits under the Retiree PPO Medical Plan. CVS Caremark (PCS) is the named fiduciary with responsibility for deciding appeals for prescription drug claims under the prescription drug program. The named fiduciary has discretionary authority to interpret the respective plan or program in order to make benefit decisions as it may determine in its sole discretion and also has discretionary authority to make factual determinations as to whether any individual is entitled to benefits under the respective plan or program.

Plan Contributions and Funding:

The cost of the benefits provided under this Plan for eligible Retirees (other than those Retirees who are former “key employees”) and their eligible dependents is funded by the Washington Gas Light Company Postretirement Benefit Master Trust for Retired Previously Union-Eligible Employees and the Washington Gas Light Company Postretirement Benefit Master Trust for Retired Management Employees (the “Post-Retirement VEBAs”). Benefits for such Retirees and their eligible dependents are paid by the Post-Retirement VEBAs. The Employer portion of the benefit for retired “key employees” is funded through the general assets of the Employer.

SUMMARY PLAN DESCRIPTION
As of January 1, 2020

	Retiree benefits may also be funded by contributions from Retirees and their eligible dependents.
Trustee:	The Bank of New York Mellon One Wall Street 11th Floor New York, NY 10286
Agent for the Service of Legal Process:	The principal agent for service of legal process is: Corporate Secretary Washington Gas Light Company 1000 Maine Avenue SW Washington, DC 20024 Service for legal process may also be made on the Plan Administrator.
Collective Bargaining Information:	The plan is subject to collective bargaining agreements with unions representing eligible employees as follows: IBT – Local 96 2120 Bladensburg Road, NE Suite 106 Washington, DC 20018 OPEIU – Local 2 8455 Colesville Road Suite 1250 Silver Spring, MD 20910-3311 IBEW – Local 1900 1300 Mercantile Lane Suite 202 Largo, MD 20774
No Contract of Employment:	The Plan, any changes to it, or any payments to you under its terms does not constitute a contract of employment with your Employer and does not

give you the right to be retained for any specific period of time.

Legal Plan Document and Disclaimer: This document serves as the “summary plan description” required by law. Save this document and refer to it when any questions arise. You can obtain a copy of this Summary Plan Description or the Plan document upon written request to the Plan Administrator. A reasonable charge may be made for copying this information. Copies of other plan documents are available for review through the Washington Gas Human Resources Department.

SUMMARY PLAN DESCRIPTION
As of January 1, 2020

STATEMENT OF ERISA RIGHTS

As a participant in the CareFirst Retiree PPO Medical Plan and CVS Caremark prescription drug program you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office during normal business hours and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report, if any (the Plan Administrator is required by law to furnish each participant with a copy of this summary annual report).

Continue Group Health Plan Coverage

You are entitled to continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a COBRA qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

SUMMARY PLAN DESCRIPTION
As of January 1, 2020

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 1-866-444-3272.

SUMMARY PLAN DESCRIPTION
As of January 1, 2020

HOW THE RETIREE PPO PROGRAM WORKS

In-Network vs. Out-Of-Network Coverage
The Retiree Preferred Provider Organization ("PPO") program option offers two levels of medical benefits. Covered persons may select the benefit level at which coverage will be provided each time care is sought. Under the Retiree PPO program option, covered persons may receive benefits for a particular service under either the in-network component or the out-of-network component. A covered person may not receive duplicate benefits for the same services. Benefits will be paid only when Medically Necessary as determined by CareFirst.

A listing of Preferred Providers is available from CareFirst upon request and is subject to change. You may confirm the status of any Provider prior to making arrangements to receive care by contacting CareFirst.

In-Network Option

When in-network coverage applies, covered persons are eligible for a higher level of benefits than the out-of-network benefits. In-network benefits apply in the following instances:

- **Services Rendered by a Preferred Provider** - When covered persons use a Preferred Provider, benefits are based on the appropriate Allowed Benefit. The level of benefits is reflected in the Schedule of Benefits. Preferred Providers will submit claims to CareFirst directly for Covered Services. The Preferred Provider will accept 100% of the Allowed Benefit as full payment for Covered Services subject to any coinsurance and/or copayment under the in-network Schedule of Benefits.

- **Other Circumstances** –

  - When a Preferred Provider refers a covered person to a non-Preferred Provider, CareFirst will pay the in-network benefit.

  - A covered person may request a referral to a Specialist (or a Non-Physician Specialist) who is a Non-Preferred Provider if the covered person is diagnosed with a condition or disease that requires specialized health care services or medical care, and (1) CareFirst does not contract with a Specialist or Non-Physician Specialist with the necessary professional training and expertise, or (2) CareFirst cannot provide reasonable access to a contracted Specialist or Non-Physician Specialist with the necessary professional training and expertise without unreasonable delay or travel.

For this purpose, a Specialist is a physician who is certified or trained in a specified field of medicine, and a Non-Physician Specialist is a provider who is not a licensed or certified physician under applicable state law and is certified or trained to treat or provide health care services for a specified condition or disease in a manner that is within the scope of his/her license or certification.

In each of these instances, benefits will be based on the appropriate Allowed Benefit for the service or supply provided. The level of benefits (i.e., coinsurance and/or copayment) for these providers' services will be those shown under the in-network option in the Schedule of Benefits. Covered persons may be responsible for amounts in excess of the Allowed Benefit.

Out-of-Network Option

Coverage under the out-of-network option applies if the covered person obtains Covered Services from a Non-Preferred Provider in a circumstance not addressed above. When the out-of-network option applies, covered persons will receive reduced benefits for Covered Services. When covered persons use a Non-Preferred Provider, payment is based on the appropriate Allowed Benefit. The level of out-of-network benefits is shown in the Schedule of Benefits. A Non-Preferred Provider is not required to accept the Allowed Benefit as payment in full and may collect additional amounts from the covered person up to its actual charge. Covered persons may be responsible for amounts in excess of the Allowed Benefit for these services.

The Allowed Benefit for out-of-network services is based upon the lesser of the provider's actual charge or established fee schedule, which, in some cases, will be a rate specified by applicable law. For more information on the Allowed Benefit, please contact CareFirst at (800) 628-8549 or log into your account at http://www.carefirst.com.

Filing a Claim

If you see a Non-Preferred Provider, you are responsible for filing a claim form or for ensuring that your doctor's office or hospital files one for you. As previously mentioned, if you see a Preferred Provider, you will not need to file a claim.

Claim forms are available in Human Resources, or by calling CareFirst BlueCross BlueShield Member Services at 1-800-628-8549, or on their website www.carefirst.com (select claim forms, then select Blue Preferred). Attach an itemized bill to your completed claim form and submit to:

SUMMARY PLAN DESCRIPTION
As of January 1, 2020

CareFirst BlueCross BlueShield
P.O. Box 45114
Lexington, KY 40512-4114

Claims must be submitted to CareFirst BlueCross BlueShield within 15 months of the date the services or supplies were received. Notwithstanding the foregoing, claims submitted with regard to routine vision care must be submitted within 12 months after the date the Covered Service is received. CareFirst BlueCross BlueShield will only consider claims beyond the applicable filing limit if it was not reasonably possible to submit the proof within the required time, the proof is submitted as soon as reasonably possible, and, except in the absence of legal capacity of the covered person, not later than one 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 Plan. 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 claim. CareFirst provides forms for this purpose.

The timely filing period for prescription drug claims is addressed in "Prescription Drug Benefits" below.

You should keep copies of all bills for your records. Your original bills will not be returned.

SUMMARY PLAN DESCRIPTION
As of January 1, 2020

GENERAL FEATURES OF THE MEDICAL BENEFIT

This section addresses general features of the Retiree PPO Medical Program and the medical benefits it provides. Features of the Prescription Drug Benefit Program are addressed in the section of the SPD entitled "Prescription Drug Benefits."

Annual Deductible - Medical

For all benefits except as stated in the Description of Covered Services, you must first meet an annual deductible before the Plan will begin to provide benefits, as provided in the following chart.

DEDUCTIBLE - MEDICAL			
In-Network		**Out-of-Network**	
Individual	**Family**	**Individual**	**Family**
$100	$200	$500	$1,000
The following amounts apply to the Deductible:		**The following amounts may not be used to satisfy the Deductible:**	
• 100% of the Allowed Benefit for Covered Services that are subject to the Deductible		• Charges in excess of the Allowed Benefit • Charges for services which are not covered under the Plan or which exceed the Plan's maximum number of covered visits/days • Charges for Covered Services not subject to the Deductible	

The deductible is calculated based on the Allowed Benefit of Covered Services.

Your deductible will depend on the level of coverage you have selected and whether services are rendered in- or out-of-network. Note that costs related to the Prescription Drug Benefits program do not count toward the Retiree PPO Program deductible.

If you have family coverage and two covered family members each satisfy the individual deductible, this will satisfy the deductible for all other covered family members. A covered family member may not contribute more than the individual deductible amount to the family deductible amount. The Plan pays benefits for a family member in family coverage who reaches the individual Deductible amount before the family Deductible amount is reached.
If you use a combination of both in-network and out-of-network services in one year, your maximum deductible for using both coverage options will be the out-of-network deductible.

After you meet the deductible, you will also be responsible for copayments and coinsurance. The additional out-of-pocket costs will depend on whether services are rendered in-network or out-of-network.

Co-payment

Co-payments are fixed dollar amounts that you may have to pay for certain services.

Co-insurance

For all out-of-network and some in-network services, you are responsible for a percentage of the cost of services you and your eligible dependents receive, called co-insurance.

Preferred Providers have agreed to accept a fixed amount for each service offered by the Plan, called the Allowed Benefit. For most in-network services, you will pay a percentage of the Allowed Benefit. All in-network preventive services required to be covered as preventive under the Affordable Care Act are covered by the Plan at 100% of the Allowed Benefit.

If you go to an out-of-network provider, the Plan will cover a percentage of the Allowed Benefit for Covered Services you and your eligible dependents receive.

Out-of-Pocket Limit - Medical

To protect you and your family from the cost of a catastrophic illness or accident, there is a limit on the amount of out-of-pocket medical expenses you will be expected to incur for Covered Services every calendar year (the "out-of-pocket limit"), as provided in the following chart.

<table>
<tr><th colspan="4">OUT-OF-POCKET LIMIT - MEDICAL</th></tr>
<tr><th colspan="2">In-Network</th><th colspan="2">Out-of-Network</th></tr>
<tr><th>Individual</th><th>Family</th><th>Individual</th><th>Family</th></tr>
<tr><td>$1,500</td><td>$3,000</td><td>$3,000</td><td>$6,000</td></tr>
<tr><th colspan="2">The following amounts apply to the out-of-pocket limit:</th><th colspan="2">The following amounts do <u>not</u> apply to the out-of-pocket limit:</th></tr>
<tr><td colspan="2">• Coinsurance (covered person's share)
• Copays
• Deductible</td><td colspan="2">• Charges in excess of the Allowed Benefit

• Amounts paid by covered persons for services provided under the Prescription Drug Benefit</td></tr>
</table>

After your costs reach the out-of-pocket limit, the Plan will pay 100% of your Allowed Benefit as outlined in the Schedule of Benefits for the remainder of the Benefit Period. Note that costs related to the Prescription Drug Benefits program do not count toward the medical out-of-pocket limit. The out-of-pocket limit for the Prescription Drug Benefits program is described in the section of the SPD entitled “Prescription Drug Benefits.”

If you use a combination of in- and out-of-network services, the amount of money spent for each type of service can be combined to meet your out-of-pocket limits.

If you have family coverage, eligible expenses of all eligible covered persons can be combined to meet your family out-of-pocket limit. However, one eligible dependent cannot contribute more than the individual limit toward meeting the family limit.

Lifetime Maximum

There is an unlimited Lifetime Maximum on the dollar value of essential health benefits.

Annual Maximum

The plan does not impose an annual limit on the dollar value of essential health benefits.

SUMMARY PLAN DESCRIPTION
As of January 1, 2020

COMMONLY ASKED QUESTIONS AND ANSWERS

Q. My family and I are planning to vacation in another state. What should we do if we need a doctor or hospital while we are gone?

A. When you enrolled in CareFirst, you were automatically enrolled in the *BlueCard Program*. With this program, you can see any BlueCross BlueShield Preferred Provider and receive the same level of coverage as if you saw a Preferred Provider at home.

To receive care when you are away from home, call (800) 810-BLUE (2583) or (804) 673-1177 (collect calls accepted) for information on the nearest Preferred Provider doctors and hospitals. The doctor you see will submit claim forms for you but you will be responsible for obtaining authorization for specialty services through Utilization Management.

Q. How do I know when I have to obtain special authorization to receive coverage?

A. You must get pre-authorization from the Utilization Management Department for certain services. If you receive in-network services, you or your doctor will arrange for pre-authorization. If you go out-of-network, you are responsible for calling Utilization Management at 866-PREAUTH (773-2884) and arranging your care.

If you have questions about CareFirst BlueCross BlueShield, your options, Covered Services, your level of coverage, or any other aspect of your Plan, call CareFirst at:

800-628-8549

SUMMARY PLAN DESCRIPTION
As of January 1, 2020

ELIGIBILITY AND ENROLLMENT

Eligibility Requirements-Who Is Eligible?

Retirees - General Eligibility Rules

Subject to the Special Eligibility rules described below, eligible Retirees are former employees of Washington Gas Light Company or other Employer whose employment ends on or after January 1, 2013 due to retirement on or after January 1, 2013 with ten or more years of continuous service determined pursuant to the Employer's personnel records and are:

1. immediately eligible for pension benefits under the Employer's defined benefit pension plan, have worked continuously until retirement, elected to have pension benefits begin immediately upon retirement, completed the paperwork necessary to be receiving such benefits within 30 days prior to their retirement date, and were enrolled in the Washington Gas Employees Group Medical Plan immediately prior to retirement; or

2. management employee retirees who made an irrevocable election under the Retirement Choice program to stop earning additional benefits under the Employer's defined benefit pension plan and instead receive an enhanced benefit under the Employer's 401(k) plan, have (i) worked continuously for the Employer until attainment of age 55 or later, (ii) elected to have any pension benefits payable under the company's defined benefit pension plan begin immediately upon retirement, and (iii) completed the paperwork necessary to be receiving such benefits within 30 days prior to their retirement date, and were enrolled in the Washington Gas Employees Group Medical Plan immediately prior to retirement; or

3. employee retirees first hired (or rehired) on or after the dates described in the chart directly below who are not eligible to participate in the Employer's defined benefit pension plan, who have worked continuously for the Employer until attainment of age 55 or later, and were enrolled in the Washington Gas Employees Group Medical Plan immediately prior to retirement; provided, however, that if any such retirees are rehired employees who have benefits payable under the Employer's defined benefit pension plan from a prior period or periods of employment, the requirements under paragraph (1) and (2), above, must be satisfied.

SUMMARY PLAN DESCRIPTION
As of January 1, 2020

Hire Date	Employee Group / Bargaining Unit
January 1, 2009	International Brotherhood of Teamsters & OPEIU Local 2
July 1, 2009	Management Employees
January 1, 2010	IBEW Local 1900 & Hampshire Gas Employees

Retirees also include those individuals who retired prior to January 1, 2013 provided the Retiree was covered as a Retiree under the Washington Gas Light Company Employees' Group Medical Plan as of December 31, 2012.

Retirees also include those individuals who retire from employment with WGL Energy Services, Inc. and WGL Energy Systems, Inc., but only if they worked continuously for Washington Gas Light Company and/or Hampshire Gas Company immediately prior to transferring employment to WGL Energy Services, Inc. or WGL Energy Systems, Inc. and such transfer occurred on or after January 1, 2016.

Retirees – Special Eligibility Rules

Retirees who cease to be eligible shall no longer be eligible to participate in the Plan.

If a Retiree who is covered under the Retiree PPO Plan subsequently becomes employed by an Employer and eligible for active health coverage with that Employer, then the Retiree shall cease to be eligible under the Plan.

If a Retiree is covered under the Retiree PPO Plan, and subsequently becomes employed and eligible for active health coverage with an employer other than an Employer or an affiliate, then the Retiree's coverage under the Retiree PPO Plan will be secondary.

Upon reaching age 65, a Retiree shall cease to be eligible under the Retiree PPO Plan but may become eligible for the WGL Retiree HRA Plan. Please see the WGL Retiree HRA Plan summary plan description for more information.

A Retiree may cover his/her legal spouse as a dependent. A Retiree cannot cover a former spouse once divorced or if the marriage has been annulled. If a Retiree is separated but still legally married, his or her spouse may still be covered. A spouse who is employed by an Employer or an affiliate of an Employer shall not be eligible for coverage under the Retiree PPO Plan until his or her employment ceases, but a spouse who is otherwise eligible for coverage shall be eligible to enroll in the Retiree PPO Plan within 30 days following his or her termination of employment with the Employer. Upon reaching age 65, a spouse shall cease to be eligible under the Retiree PPO Plan but may become eligible for the WGL Retiree HRA Plan. Please see the WGL Retiree HRA Plan summary plan description for more information.

Coverage for domestic partners is not available.

Children - Children who are eligible for coverage include:

- Your child, as defined in Internal Revenue Code section 152(f)(1) (i.e., a natural child, an adopted child or child placed with you for adoption, a stepchild, or a foster child placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction) and your grandchild who is in your court-ordered custody, provided that the child has not reached age 26 and is not eligible for other employer-provided health coverage by virtue of his or her employment, or, if he or she is married, by virtue of his or her Spouse's employment.

- Your unmarried child who has reached age 26 who is incapable of self-support because of mental or physical incapacity that began before the child reached age 26 qualifies as an eligible dependent provided the child also resides with you for more than half of the year (temporary absences due to illness, education, vacation and similar circumstances are not treated as absences) and does not provide more than half of his or her own support. Proof of the child's certified medical incapacity must be provided to the HR Service Center within 30 days after the child's coverage would otherwise terminate or within 30 days after the child's date of coverage under the Plan, whichever is later. You may also be required to provide the HR Service Center from time to time with additional proof of whether the child is and continues to qualify as an incapacitated child.

Children whose relationship to the Retiree is not listed above are not covered under the Plan even though the child may live with you and be dependent upon you for support. The Plan has the right to request documentation from you to verify that a child qualifies for coverage as a dependent child. A child who is employed by an Employer or an affiliate of an Employer shall not be eligible for coverage under the Plan until his or her employment ceases, but a child who is otherwise eligible for coverage shall be eligible to enroll in the Plan within 30 days following his or her termination of employment with the Employer. Upon reaching age 65, the child shall cease to be eligible under the Retiree PPO Plan but may become eligible for the WGL Retiree HRA Plan. Please see the WGL Retiree HRA Plan summary plan description for more information.

When a subsequent change takes place in the status of dependents, please contact the HR Service Center promptly (and no later than 30 days after the change) to process the change and submit proper documentation.

Eligible Dependents at Retirement

Only dependents that were covered by the Washington Gas Light Company Employees Group Medical Plan on the date of the Retiree's retirement may be covered under the above provisions. A Retiree cannot add a spouse or child to his or her coverage after the date on which he or she retires. A Retiree's child, if any, will automatically cease to be covered on the date he or she no longer qualifies as a dependent as previously defined in this booklet. This limitation does not apply to spouses and other eligible dependents who are also employed by Washington Gas. Spouses and other eligible dependents who are employed by Washington Gas on the date of the Retiree's retirement shall be eligible to enroll in the Plan within 30 days following their termination of employment with Washington Gas.

Dependent Coverage at Death of a Retiree

Upon the death of a Retiree, the Retiree's participation in the Retiree PPO Plan will automatically cease. However, in general, coverage then in effect for the surviving spouse and children will continue in effect, unless the spouse remarries, which would cause his/her coverage to cease. Please see "Termination of Coverage" for more information on when coverage ends.

Enrollment Requirements

Retiree Enrollment

To become covered by the Retiree PPO Plan, you must complete an enrollment application for you and your spouse and/or children. You will be given an application form to complete. You must return the completed form to Human Resources within 30 days from the date Human Resources provides the application. If you do not enroll within this period, you, your spouse, and your children will not be eligible for the Plan. After your initial enrollment in the Retiree PPO Plan, you and your spouse and/or children will be automatically re-enrolled in the Retiree PPO Plan each year unless you, your spouse and/or children cease to be eligible or if you, your spouse and/or children decide to cease participation in the Retiree PPO Plan. You will be notified of your share of the cost of coverage each year.

Qualifying Events

The Plan permits eligible Retirees to change their medical plan coverage during the year only if they experience a qualifying event in one of the categories listed below and the requested change is consistent with the event. In order to change your election, you may be required to provide proof verifying that the qualifying event has occurred. Most

coverage changes are effective within the following pay period once all documentation is received and online enrollment has been completed.

Eligible qualifying events are:

- Termination of the other plan's entire group coverage;
- A change in legal marital status (including marriage, divorce, legal separation, annulment or death of a spouse);
- A change in your, your spouse's, or a dependent's employment status that results in gaining or losing eligibility for coverage under a plan (including beginning or ending employment, a reduction or increase in hours of employment, a strike or lockout, starting or returning from an unpaid leave of absence, or changing from part-time to full-time employment or vice versa);
- Your eligible dependent ceases to satisfy the requirements for dependent child due to the attainment of age or any similar circumstances;
- A change in the place of residence or work for you or your eligible dependents if the change results in you or your eligible dependents living outside the network service area;
- Any event that changes your number of eligible dependents; and
- You or your eligible dependents (including your spouse) becomes entitled to Medicare or Medicaid.

Time Period for Making Changes: If you experience one of the events described above and want to change coverage due to such event, you must contact the HR Service Center to enroll and present approved documentation within 30 days from the date of the qualifying event. If you do not process your enrollment with the HR Service Center within the 30-day period, then any change will be made effective on the first day of the month following the date that the change request and all required documentation is received. You may terminate coverage for a spouse or dependents, but you cannot add anyone new to your coverage.

Consistency Requirements: An election change must be on account of and consistent with the event. Thus, the event must affect eligibility for coverage under the Plan or under a plan sponsored by your dependent's employer, and the election change must correspond with the event.

SUMMARY PLAN DESCRIPTION
As of January 1, 2020

PLEASE NOTE: Fraudulent enrollment of dependents amounts to theft, which may result in immediate discharge from employment and criminal prosecution.

Enrolling a Child Under A Qualified Medical Child Support Order

If a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody (including a Qualified Medical Child Support Order (QMCSO)) requires your child to be covered under the Plan, you may change your election to provide coverage for the child. If the order requires that another individual (such as your spouse or former spouse) provide coverage for the child, then you may change your election to revoke coverage for the child, provided that such coverage is, in fact, provided for the child.

If you have any questions about eligibility for you or your dependents, contact the HR Service Center.

Qualified Medical Child Support Orders (QMCSOs)

This Plan will extend benefits to a Retiree's non-custodial child, as required by any qualified medical child support order (QMCSO). A QMCSO is a court order giving a child who otherwise might not be eligible for medical coverage provided under the Plan a right to such coverage. Typically, the court in connection with a divorce or separation issues such an order. Before complying with a QMCSO, a determination must be made as to whether the court order meets the legal requirements to qualify as a QMCSO. You will be notified if a court order relating to you is received by the Plan and the procedure used by the Plan to determine whether the order is a QMCSO. A copy of the Plan's procedures for determining whether an order qualifies as a QMCSO may be obtained, without charge, from the Plan Administrator.

Required Contributions

For a description of the Plan's procedures for payment of required contributions by Retirees (and their eligible dependents), refer to the paragraph entitled Required Contributions and Termination for Non-Payment, under the Section entitled Termination of Coverage herein.

SUMMARY PLAN DESCRIPTION
As of January 1, 2020

TERMINATION OF COVERAGE

Voluntary/Involuntary Terminations

Unless coverage is continued as described in Continuation of Coverage, COBRA:

If you no longer meet the Plan's eligibility requirements, all of your coverage will cease at the end of the month. Coverage for your eligible dependents ends on the date your coverage ends, or the date an individual ceases to be an eligible child, whichever is sooner.

If you die, your coverage will cease on the date of your death. If you have a surviving spouse, (1) he/she will continue to be covered until the earlier of his/her attainment of age 65, his/her remarriage, or his/her death, and (2) any dependent child will remain covered until he/she attains age 26. If you do not have a surviving spouse but you do have a surviving dependent child, your child's coverage will cease on the date of your death (subject to any COBRA continuation coverage rights). If such surviving child is an adult disabled child, your child's coverage will cease on the date of your death (subject to any Medicare and COBRA continuation coverage rights).

If you voluntarily terminate coverage under the Plan, your coverage will end on the date you voluntarily terminate coverage. Coverage for your spouse and any dependent children will also end on such date.

If you get divorced, coverage for your spouse will end on the day of the month that the divorce was granted.

You must notify your Employer's Human Resources if your dependent reaches the limiting age or if there is a change such that he/she no longer meets the eligibility requirements for a dependent. If you do not provide such notice and it is later determined that your dependent was ineligible for coverage, the Plan may recover from you or your dependent the full value of the services and benefits provided during the period of ineligibility.

Required Contributions and Termination for Non-Payment

Retirees and their eligible surviving spouses and surviving children are required to pay a portion of the monthly cost for medical coverage. You will be informed of your monthly payment amount, and how payment is to be made, before the beginning of the year if there is a change in the amount or payment process. If there is a mid-year increase or decrease in your monthly payment amount, you will be provided with reasonable notice of the applicable cost change. In accordance with Plan procedures, if you or your dependent fail to timely make the full required Plan contribution as described below, the Plan coverage to which the contribution applies will terminate as of the first day of the period for which the

contribution was not timely paid. This means that the bills for medical services and prescription drugs that you received after the last day of the month for which you had made a contribution will **not** be covered by the Plan, and your doctors, pharmacy or other providers may seek payment in full from you for those services.

Retirees and their Eligible Surviving Spouses and Surviving Children

If you are a Retiree (or the eligible surviving spouse or surviving child of a Retiree) and are eligible for a pension benefit under the Company's defined benefit pension plan, you may have the monthly contribution amount deducted from your monthly pension benefit under the Washington Gas Light Company Employees' Pension Plan and sent directly to the Company. If your pension benefit isn't enough to cover the contribution amount, or you are not eligible for pension benefits under the pension plan, you will be billed and may make your monthly payments directly to the Company by personal check or money order made payable to Washington Gas. If you don't elect a payment method, we will deduct the contribution amount from your monthly pension benefit (if there are sufficient funds) until you instruct otherwise.

If you are paying directly, it's important that you make your monthly contribution payments on time. The direct bill grace period for payments is 30 days. Payments are due on the first day of the month with a net 30 day grace period. If you do not pay the premium due by the end of the 30-day grace period, your Plan coverage will end on such date and a termination letter will be mailed to you. Any claims presented to the Plan from you, your doctors, prescription drug pharmacy, or other providers for any month your payment is late will be denied until you pay the past due contribution amount. If your medical coverage is terminated for non-payment of the monthly contribution amount, unless there are extenuating circumstances, you and any enrolled dependents will not be entitled to return to this Plan or to any other Company-sponsored retiree medical plan in the future.

Retirees (and eligible surviving spouses and surviving dependents of Retirees) may voluntarily elect in writing to discontinue their medical and prescription drug coverage under the Plan at any time. For example, a Retiree may elect to stop coverage when he retires or at some future date after retirement. However, if you elect to discontinue your coverage, you and your enrolled dependents will not be eligible to return to this Plan or to any other Company-sponsored retiree medical plan in the future.

Termination of Coverage

In addition to the other termination rights discussed in this "Termination of Coverage" section, a covered person's coverage under the Plan can terminate if:

- The covered person allowed another person to use his/her identification card or the covered person used another person's identification card. The identification card must be returned to CareFirst upon request.

- The covered person made an intentional misrepresentation of information, which was material to the acceptance of the application when the covered person represented that all information contained in the enrollment application was true, correct and complete to the best of the covered person's knowledge and belief.

- The covered person made an intentional misrepresentation of any information required by CareFirst on any forms or other written requests for data. Such information will include but not be limited to requests for medical information, coordination of benefits information, subrogation information, employment status and dependent eligibility status.

- The covered person or the covered person's representative made fraudulent misstatements related to coverage or benefits under the contract.

No Rescission of Coverage

Coverage shall not be cancelled or discontinued with a retroactive effect with respect to a Retiree, spouse, or child except in the event of fraud or intentional misrepresentation or termination for non-payment. At least 30 days' advance written notice will be provided before coverage is rescinded.

Termination of Coverage in Event of Plan Termination

In the event that the Plan is terminated, all coverage under the Plan shall terminate as of the Plan's termination date.

SUMMARY PLAN DESCRIPTION
As of January 1, 2020

CONTINUATION COVERAGE RIGHTS UNDER COBRA

COBRA continuation coverage is a temporary extension of group health coverage under certain circumstances when coverage would otherwise end. The right to COBRA coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage can become available to you when you would otherwise lose your group health coverage under the Plan. It can also become available to your spouse and dependent children, if they are covered under the Plan, when they would otherwise lose their group health coverage under the Plan. **The following generally explains COBRA coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The Plan provides no greater COBRA rights than what COBRA requires--nothing in this summary is intended to expand your rights beyond COBRA's requirement.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA Coverage?

COBRA coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below in the section entitled "Who Is Entitled to Elect COBRA?"

COBRA coverage may become available to "qualified beneficiaries"

After a qualifying event occurs and any required notice of that event is properly provided to the Company, COBRA coverage must be offered to each person losing coverage who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the Plan is lost because of the qualifying event. (Certain newborns, newly adopted children, and alternate recipients under QMCSOs may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.)

We use the pronoun "you" in the following paragraphs regarding COBRA to refer to each person covered under the Plan who is, or may become, a qualified beneficiary.

COBRA coverage is the same as coverage available to other participants or beneficiaries under the Plan

COBRA coverage is the same coverage that is given to other participants or beneficiaries who are not receiving COBRA coverage. Each qualified beneficiary who elects COBRA will have the same rights under the Plan as other participants or beneficiaries, including open enrollment and special enrollment rights. Qualified beneficiaries who elect COBRA must pay for COBRA coverage.

Who Is Entitled to Elect COBRA?

Qualifying events for the covered spouse

If you are the spouse of a Retiree, you will be entitled to elect COBRA if you lose your coverage under the Plan because the following qualifying event happens:

- you become divorced from your spouse. Also, if your spouse (the Retiree) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or separation.

Qualifying events for dependent children

If you are the dependent child of a Retiree, you will be entitled to elect COBRA if you lose your coverage under the Plan because the following qualifying event happens:

- you stop being eligible for coverage as a “dependent child.”

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Employer, and that bankruptcy results in the loss of your coverage and you are a Retiree or the spouse, surviving spouse, or dependent child of a Retiree, you will become a qualified beneficiary.

When Is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the plan administrator has been notified that a qualifying event has occurred. The Employer must notify the plan administrator of the following qualifying events:

- Commencement of a proceeding in bankruptcy with respect to the Employer.

For the other qualifying events (divorce or legal separation of the Retiree and spouse or a dependent child's losing eligibility for coverage as a dependent child), a COBRA election will be available to you only if you notify the COBRA Administrator in writing within 60 days after the later of (1) the date of the qualifying event or (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event.

COBRA Administrator:
WageWorks, Inc.
www.wageworks.com
Phone: (877) 502-6272

Address for COBRA Elections:
PO Box 14055
Lexington, KY 40512-4055
Fax: (877) 220-3249

Address for COBRA Premium Payments:
1155 Reliable Parkway
Chicago, IL 60686-0011

No COBRA election will be available unless you follow the notice procedures and meet the notice deadline

You must mail or fax the notice to the COBRA Administrator. The notice must be in writing and include the name of the Retiree and qualified beneficiary, and indicate whether the qualifying event is due to a divorce or a covered child's loss of dependent status. It must also include appropriate documentation of the qualifying event such as a copy of a divorce decree, proof that the dependent child no longer satisfies the definition of dependent under the applicable health plan, and/or other appropriate documentation as deemed by the COBRA Administrator to support your request. If these procedures are not followed or if the notice is not provided in writing to the COBRA Administrator during the 60-day notice period, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA.

Electing COBRA Continuation Coverage

How to elect COBRA

To elect you must complete the election process through the COBRA Administrator (addresses provided above). Under federal law, you must have 60 days after the date of

the COBRA election notice provided to you at the time of your qualifying event to decide whether you want to elect COBRA continuation coverage.

The Election Form must be completed in writing and mailed or faxed to the address as specified above.

Deadline for COBRA Election

Your election must be postmarked no later than 60 days after the date of the COBRA election notice provided to you at the time of your qualifying event.

Independent election rights

Each qualified beneficiary will have an independent right to elect COBRA. For example, the Retiree's spouse may elect COBRA even if the Retiree does not. COBRA may be elected for only one, several, or for all dependent children who are qualified beneficiaries. Covered Retirees and spouses (if the spouse is a qualified beneficiary) may elect COBRA on behalf of all of the qualified beneficiaries, and parents may elect COBRA on behalf of their children. **Any qualified beneficiary for whom COBRA is not elected within the 60-day election period specified in the Plan's COBRA election notice WILL LOSE HIS OR HER RIGHT TO ELECT COBRA COVERAGE.**

Notify us if a qualified beneficiary is entitled to Medicare before electing COBRA

When you complete the COBRA election process, you must notify the COBRA Administrator if any qualified beneficiary has become entitled to Medicare (Part A, Part B, or both) and, if so, the date of Medicare entitlement. If you become entitled to Medicare (or first learn that you are entitled to Medicare) after submitting your election, immediately notify the COBRA Administrator of the date of your Medicare entitlement at the address specified above for delivery of the Election Form.

Which Plans may be elected?

Qualified beneficiaries may be enrolled in one or more group health plans at the time of a qualifying event. If a qualified beneficiary is entitled to a COBRA election as the result of a qualifying event, he or she may elect COBRA under any or all of the group health plans under which he or she was covered on the day before the qualifying event. (For example, if a qualified beneficiary was covered under the medical and dental components on the day before a qualifying event, he or she may elect COBRA under dental only, under medical only, or under both dental and medical. Such a qualified beneficiary could not elect COBRA under the vision plan because he or she was not covered under that plan on the day before the qualifying event.)

Is COBRA coverage available if a qualified beneficiary has other plan coverage or Medicare?

Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health plan coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, as discussed in more detail below, a qualified beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied). See the section below entitled "Termination of COBRA Coverage Before the End of the Maximum Coverage Period."

Special Consideration in Deciding Whether to Elect COBRA

In considering whether to elect COBRA, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage under the plan ends because of one of the qualifying events listed above. You will also have the same special enrollment right at the end of COBRA coverage if you get COBRA coverage for the maximum time available to you.

Length of COBRA Coverage

COBRA coverage is a temporary continuation of coverage. The COBRA coverage periods described below are maximum coverage periods. COBRA coverage can end before the end of the maximum coverage period for several reasons, which are described in the section below entitled "Termination of COBRA Coverage Before the End of the Maximum Coverage Period."

When coverage is lost due to the Retiree's divorce or legal separation or a dependent child's losing eligibility as a dependent child, COBRA can last for up to 36 months.

Termination of COBRA before the End of the Maximum Coverage Period

COBRA coverage will automatically terminate before the end of the maximum period if:

- any required premium is not paid in full on time;
- a qualified beneficiary becomes covered, after electing COBRA, under another group health plan (but only after any preexisting condition exclusions of that other plan for a preexisting condition of the qualified beneficiary have been exhausted or satisfied);

- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA;
- the employer ceases to provide any group health plan for its employees; or

COBRA coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving COBRA coverage (such as fraud).

You must notify the COBRA Administrator if a qualified beneficiary becomes entitled to Medicare or obtains other group health plan coverage

You must notify the COBRA Administrator (addresses provided above) in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare (Part A, Part B, or both) or becomes covered under other group health plan coverage (but only after any preexisting condition exclusions of that other plan for a preexisting condition of the qualified beneficiary have been exhausted or satisfied).

Nature of Coverage

COBRA coverage must consist of coverage which, as of the time the coverage is being provided, is identical to the coverage provided under the plan to similarly situated beneficiaries under the plan with respect to whom a qualifying event has not occurred.

Cost of COBRA Coverage

Each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of COBRA coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and retiree contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA coverage. The amount of your COBRA premiums may change from time to time during your period of COBRA coverage and will most likely increase over time. You will be notified of COBRA premium changes.

Payment for COBRA Coverage

How premium payments must be made

All COBRA premiums must be paid by check or money order, or through the COBRA Administrator's online payment portal. See above for the address for COBRA premium payments.

SUMMARY PLAN DESCRIPTION
As of January 1, 2020

When premium payments are considered to be made

Your payment is considered to have been made on the date that it is received, or the date that it is postmarked, if it is sent by U.S. Postal Service mail. You will not be considered to have made any payment by mailing a check if your check is returned due to insufficient funds or otherwise.

First payment for COBRA coverage

If you elect COBRA, you do not have to send any payment with the Election Form. However, you must make your first payment for COBRA coverage not later than 45 days after the date of your election. (This is the date your Election Form is received, or the date it is postmarked, if it is sent by U.S. Postal Service mail.)

Your first payment must cover the cost of COBRA coverage from the time your coverage under a Plan would have otherwise terminated up through the end of the month before the month in which you make your first payment. (For example, Sue's employment terminates on September 30, and she loses coverage on September 30. Sue elects COBRA on November 15. Her initial premium payment equals the premiums for October and November and is due on or before December 30 -- the 45th day after the date of her COBRA election.) You are responsible for making sure that the amount of your first payment is correct. You may contact the COBRA Administrator using the contact information provided above to confirm the correct amount of your first payment.

Claims for reimbursement will not be processed and paid until you have elected COBRA and made the first payment for it.

If you do not make your first payment for COBRA coverage in full within 45 days after the date of your election, you will lose all COBRA rights under the Plans.

Monthly payments for COBRA coverage

After you make your first payment for COBRA coverage, you will be required to make monthly payments for each subsequent month of COBRA coverage. The amount due for each month for each qualified beneficiary will be disclosed in the Election Form provided to you at the time of your qualifying event. Each of these monthly payments for COBRA coverage is due on the first day of the month for that month's COBRA coverage. If you make a monthly payment on or before the first day of the month to which it applies, your COBRA coverage will continue for that month without any break. The COBRA Administrator will send periodic notices of payments due for these coverage periods (that is, we will send a bill to you for your COBRA coverage – however, it is your responsibility to pay your COBRA premiums on time).

Grace periods for monthly COBRA premium payments

Although monthly payments are due on the first day of each month of COBRA coverage, you will be given a grace period of 30 days after the first day of the month to make each monthly payment. Your COBRA coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment.

If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage under the Plan.

More Information about Individuals Who May Be Qualified Beneficiaries

Children born to or placed for adoption with the covered retiree during a period of COBRA coverage

A child born to, adopted by, or placed for adoption with a covered retiree during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered retiree is a qualified beneficiary, the covered retiree has elected COBRA coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the retiree. To be enrolled, the child must satisfy the otherwise applicable eligibility requirements (for example, eligibility requirements regarding age and documentation).

Alternate recipients under QMCSOs

A child of the covered retiree who is receiving benefits pursuant to a qualified medical child support order (QMCSO) received by the Plan during the covered retiree's period of employment is entitled to the same rights to elect COBRA as an eligible dependent child of the covered retiree.

Are there other coverage options besides COBRA continuation coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If You Have Questions

Questions concerning your Plan should be addressed to the HR Service Center at the address below. Questions concerning your COBRA rights should be addressed to the COBRA Administrator.

Keep Your Address Updated

In order to protect your family's rights, you should keep your address updated. For active employees, this can be done through the HR Service Center. For COBRA beneficiaries, this can be done through the COBRA Administrator. You should also keep a copy, for your records, of any notices you send updating your address.

Plan Contact Information
Retirees may obtain information about COBRA coverage on request from the COBRA Administrator.

SUMMARY PLAN DESCRIPTION
As of January 1, 2020

MULTIPLE COVERAGES

Coordination of Benefits

Medical care benefits payable under this Plan will be coordinated with medical care benefits payable under other group insurance plans. This means that if a covered person incurs medical expenses, the Plan, together with any other group insurance plan under which there is coverage, will not pay more than 100% of the reasonable and customary charges for medical services covered under any of the plans.

Determination of Coordination of Benefits

If a covered person is covered under more than one medical plan, the plan that has the first obligation to pay is called the "primary" plan. Any other plan is called "secondary".

The plan sponsored by the employer of the person receiving treatment is always primary. However, if an individual is covered as an eligible dependent under two or more plans, certain rules are used to determine which plan is primary:

If the claim is for a dependent child whose parents are neither legally separated nor divorced, the primary plan is the plan of the parent whose birthday occurs first in the calendar year. If both parents have the same birthday, then the plan that covers the parent longer is the primary plan.

If the claim is for a dependent child whose parents are legally separated or divorced with joint custody, the primary plan is the plan of the parent whose birthday occurs first in the calendar year. If both parents have the same birthday, then the plan that covers the parent longer is the primary plan.

If the claim is for a dependent child whose parents are legally separated or divorced, benefits would be coordinated as follows:

- If a court decree has established which parent has financial responsibility for medical expenses, then the plan of that parent is the primary plan.

- If no court decree has established which parent has financial responsibility for medical expenses, then the primary plan would be determined as follows:

  - The plan of the parent with custody is the primary plan;
  - The plan of the spouse of the parent with custody (the stepparent) pays next;

- The plan of the parent without custody pays next;
- The plan of the spouse of the parent without custody pays last.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses 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. The plan of the other parent shall be the secondary plan. This **does not** apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

If the claim is for a person whose coverage is provided under the right of continuation pursuant to federal or state law and who is also is covered under another plan, the benefits would be coordinated as follows:

- First, the benefits of the plan covering the person as an employee, member or subscriber (or as the person's dependent);

- 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.

If none of the above rules suffices to determine the order in which benefits should be paid, then the primary plan is the plan that covered the person longer.

Right to Receive and Release Information

Certain facts are needed to apply these coordination of benefit 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 CareFirst must give CareFirst any facts it needs to pay the claim.

Recovery of Overpayment

If the amount of the payments made by the Plan is more than it should have paid under the coordination of benefit provision, it may recover the excess from one or more of:

- The persons it has paid or for whom it has paid;

- Insurance companies; or,
- Other organizations.

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

Multiple Coverage through CareFirst

If an employee is covered on this plan and another group or individual health services contract that is issued by CareFirst or an affiliated entity, he will not be entitled to duplicate benefits or payments. If duplicate coverage occurs, CareFirst will provide benefits according to this provision up to the Allowed Benefit.

Medicare Eligibility and Coordination

Once you are retired, your Washington Gas medical benefits will automatically coordinate with Medicare Part A and Part B once you or your Spouse become eligible for Medicare.

Coverage Secondary to Medicare

Except where prohibited by law, the benefits under the Plan are secondary to Medicare.

Medicare as Primary

- When benefits for Covered Services are paid by Medicare as primary, the Plan will not duplicate those payments. When CareFirst coordinates the benefits with Medicare, CareFirst 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).
- Covered persons shall agree to complete and submit to Medicare, CareFirst and/or contracting providers all claims, consents, releases, assignments and other documents required to obtain or assure payment.

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" (defined below) is provided

or is required to be provided either:

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

- From any federal, state, county or municipal or other government agency, including, in the case of service-connected disabilities, the Veterans Administration, but excluding Medicare benefits and Medicaid benefits.

"Benefit" includes a payment or any other benefit, including amounts received in settlement of a claim for benefits.

Personal Injury Protection ("PIP") Coverage

PIP is insurance coverage without regard to fault provided under a covered person's motor vehicle casualty insurance.

There will not be any reduction, limit, or exclusion of coverage due to payments made to a covered person under the covered person's PIP Policy.

Subrogation

Subrogation applies when a covered person has an illness or injury for which a third party may be liable. Subrogation requires the covered person in certain circumstances to turn over to CareFirst any rights the covered person may have against a third party. A third party is any person, corporation, insurer or other entity that may be liable to a covered person 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; (2) covered under an uninsured or underinsured policy issued to or otherwise covering a covered person; 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. CareFirst will not subrogate a recovery made under PIP policy benefits.

- The covered person shall notify CareFirst as soon as reasonably possible and no later than the time the covered person provides proof of a claim that a third party may be liable for the injuries or illnesses for which benefits are being paid.

- If a covered person 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 Plan, the payment will be

treated as having been paid to the covered person 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 a covered person under the PIP benefits of the covered person's motor vehicle insurance policy. CareFirst will not recover medical expenses from a covered person unless the covered person recovers for medical expenses in a cause of action or settlement.

- CareFirst's right of recovery is not subject to reduction for attorney's fees and costs under the "make whole" doctrine, the "fund" doctrine, the "common fund" doctrine, comparative/contributory negligence, "collateral source" rule, "attorney's fund" doctrine, regulatory diligence or any other equitable defenses that may affect the Plan's right to subrogation or reimbursement. CareFirst will reduce the amount owed by the covered person to CareFirst in accordance with applicable law.

- CareFirst will have a lien on all funds the covered person recovers up to the total amount of benefits provided. CareFirst is entitled under its right of recovery to be reimbursed for its benefit payments even if the covered person is not "made whole" for all of the covered person's damages in the recoveries that he or she receives. CareFirst may give notice of that lien to any party who may have contributed to the covered person's loss, or who may be liable for payment as a result of that loss. For purposes of this provision, "made whole" means that you fully recover all of your damages.

- CareFirst has the option to be subrogated to the covered persons' rights to the extent of the benefits provided under this Plan. This includes CareFirst's right to bring suit or file claims against the third party in the covered person's name.

- The covered person agrees to take action, furnish information and assistance, and execute such instruments that CareFirst may require while enforcing CareFirst's rights under this section. The covered person agrees not to take any action that prejudices CareFirst's rights and interests under this provision.

Please Note: Submission of any false or misleading information for purposes of obtaining benefits is a crime and may result in denial of the claim and/or discharge and/or prosecution.

SUMMARY PLAN DESCRIPTION
As of January 1, 2020

MEDICAL BENEFIT CLAIMS PROCEDURES

Questions on Claims

If you have a question about the decision on your medical claim, you should contact CareFirst directly at 800-321-3497. When discussing your claim, please refer to the explanation of benefits, and any other correspondence you may have received.

These claims procedures do not apply to your prescription drug benefits. If you have a question about your prescription drug benefits please refer to the section of this document entitled Prescription Drug Benefits.

Scope and Purpose

The Plan's claims procedures were developed in accordance with Section 503 of the Employee Retirement Income Security Act of 1974 (ERISA), which sets forth minimum requirements for employee benefit plan procedures pertaining to claims for benefits by Claimants as required by 29 CFR § 2560.503-1 (the DOL claims procedure regulation), and the Public Health Service Act (PHS Act) requirements with respect to internal claims and appeals and external review processes for non-grandfathered group health plans as set forth in 29 CFR § 2590.715-2719.

Definitions

The following terms have the meaning described below whenever such terms are used in these Claims Procedures.

"Adverse Benefit Determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Claimant's eligibility to participate in a Plan, and including a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental/Investigational or not Medically Necessary or appropriate. An Adverse Benefit Determination also includes any rescission of coverage (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time).

"Appeal (or Internal Appeal)" means review by CareFirst of an Adverse Benefit Determination.

"Claim Involving Urgent Care" means any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

- Could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function, or
- In the opinion of a physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Whether a claim is a Claim Involving Urgent Care is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine; however, any claim that a physician with knowledge of the Claimant's medical condition determines is a Claim Involving Urgent Care shall be treated as a Claim Involving Urgent Care for purposes of these Claims Procedures.

"Claimant" means an individual who makes a claim under this section. For purposes of this section, references to claimant include a claimant's authorized representative.

"External Review" means a review of an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) conducted pursuant to the External Review Process.

"Final External Review Decision" means a determination by an Independent Review Organization at the conclusion of an External Review.

"Final Internal Adverse Benefit Determination" means an Adverse Benefit Determination that has been upheld by CareFirst at the completion of the Internal Appeals process (or an Adverse Benefit Determination with respect to which the Internal Appeals process has been exhausted under the deemed exhaustion rules).

"Health Care Professional" means a physician or other Health Care Professional licensed, accredited, or certified to perform specified health services consistent with State law.

"Independent Review Organization (or IRO)" means an entity that conducts independent External Reviews of Adverse Benefit Determinations and Final Internal Adverse Benefit Determinations under the External Review Process.

"Notice or Notification" means the delivery or furnishing of information to an individual in a manner appropriate with respect to material required to be furnished or made available to an individual.

"Post-Service Claim" means any claim for a benefit that is not a Pre-Service Claim.

"Pre-Service Claim" means any claim for a benefit with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

"Relevant" A document, record, or other information shall be considered Relevant to a Claimant's claim if such document, record, or other information:

- Was relied upon in making the benefit determination;
- Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination;
- Demonstrates compliance with the administrative processes and safeguards required pursuant to these Claims Procedures in making the benefit determination; or
- Constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the Claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Claims Procedures

These procedures govern the filing of benefit claims, Notification of benefit determinations, and Appeal of Adverse Benefit Determinations (hereinafter collectively referred to as Claims Procedures) for Claimants.

These Claims Procedures do not preclude an authorized representative of a Claimant from acting on behalf of such Claimant in pursuing a benefit claim or Appeal of an Adverse Benefit Determination. Nevertheless, the Plan has established reasonable procedures for determining whether an individual has been authorized to act on behalf of a Claimant, provided that, in the case of a Claim Involving Urgent Care, a Health Care Professional, with knowledge of a Claimant's medical condition shall be permitted to act as the authorized representative of the Claimant.

These Claims Procedures contain administrative processes and safeguards designed to ensure and to verify that benefit claim determinations and Rescissions are made in

accordance with governing Plan documents and, where appropriate, Plan provisions have been applied consistently with respect to similarly situated Claimants.

In addition to the State information provided below, the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) may also be a helpful resource to a Claimant in need of assistance.

EBSA may be contacted at: 1-866-444-EBSA (3272) or www.askebsa.dol.gov.

Claims Procedures Compliance

- Failure to follow Pre-Service Claims Procedures
  - In the case of a failure by a Claimant or an authorized representative of a Claimant to follow the Plan's procedures for filing a Pre-Service Claim the Claimant or representative shall be notified of the failure and the proper procedures to be followed in filing a Claim for Benefits. This Notification shall be provided to the Claimant or authorized representative, as appropriate, as soon as possible, but not later than five days (24 hours in the case of a failure to file a Claim Involving Urgent Care) following the failure. Notification may be oral, unless written Notification is requested by the Claimant or authorized representative.
  - The above shall apply only in the case of a failure that:
    - Is a communication by a claimant or an authorized representative of a claimant that is received by the person or organizational unit designated by the Plan or CareFirst that handles benefit matters; and
    - Is a communication that names a specific claimant; a specific medical condition or symptom; and a specific treatment, service, or product for which approval is requested.
- Civil Action
  - A Claimant is not required to file more than the Appeals process described herein prior to bringing a civil action under ERISA.

Claim for Benefits

A Claim for Benefits is a request for a Plan benefit or benefits made by a Claimant in

accordance with a Plan's reasonable procedure for filing benefit claims. A Claim for Benefits includes any Pre-Service Claims and any Post-Service Claims.

Timing of Notification of Benefit Determination (Internal Claims and Appeal Process)

- The Claimant shall be notified of the determination in accordance with the following, as appropriate.
    - Urgent care claims -- In the case of a Claim Involving Urgent Care, the Claimant shall be notified of the benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Claimant shall be notified as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information necessary to complete the claim. The Claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. Notification of any Adverse Benefit Determination pursuant to this paragraph shall be made in accordance with the procedures noted under Manner and Content of Notification of Benefit Determination herein. The Claimant shall be notified of the benefit determination as soon as possible, but in no case later than 48 hours after the earlier of:
        - Receipt of the specified information, or
        - The end of the period afforded the Claimant to provide the specified additional information.

      The determination as to whether a claim involves urgent care is determined by the attending health care professional.
    - Concurrent care decisions – If an ongoing course of treatment has been approved to be provided over a period of time or number of treatments:
        - Any reduction or termination of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments shall constitute an Adverse Benefit

Determination. The Claimant shall be notified in accordance with the procedures noted under Manner and Content of Notification of Benefit Determination herein, of the Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to file an Appeal and obtain a determination on review of the Adverse Benefit Determination before the benefit is reduced or terminated.

- Any request by a Claimant to extend the course of treatment beyond the period of time or number of treatments that is a Claim Involving Urgent Care shall be decided as soon as possible, taking into account the medical exigencies. The Claimant shall be notified of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim, provided that any such claim is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Notification of any Adverse Benefit Determination concerning a request to extend the course of treatment, whether involving urgent care or not, shall be made in accordance with the procedures noted under Manner and Content of Notification of Benefit Determination herein, and Appeal shall be governed by the procedures noted under Timing of Notification of Determination of Appeal herein as appropriate.

- Continued coverage will be provided pending the outcome of an Appeal.

o Other claims – In the case of a claim that is not a Claim Involving Urgent Care or a concurrent care decision, the Claimant shall be notified of the benefit determination in accordance with the below Pre-Service Claims or Post-Service Claims, as appropriate.

- Pre-Service Claims – In the case of a Pre-Service Claim, the Claimant shall be notified of the benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim. This period may be extended one time for up to 15 days, provided that CareFirst both determines that such an extension is necessary due to matters beyond its control and notifies the Claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered. If such an extension is necessary due to a failure of the Claimant to submit the information

necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the Notice within which to provide the specified information. Notification of any Adverse Benefit Determination pursuant to this paragraph shall be made in accordance with the procedures noted under Manner and Content of Notification of Benefit Determination herein.

- Post-Service Claims – In the case of a Post-Service Claim, the Claimant shall be notified, in accordance with the procedures noted under Manner and Content of Notification of Benefit Determination herein, of the Adverse Benefit Determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time for up to 15 days, provided that CareFirst both determines that such an extension is necessary due to matters beyond its control and notifies the Claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the Notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the Notice within which to provide the specified information.

- Calculating time periods – For purposes of the procedures noted under Timing of Notification of Benefit Determination herein, the period of time within which a benefit determination is required to be made shall begin at the time a claim is filed, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended as permitted pursuant to item Other Claims above due to a Claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information.

- Deemed exhaustion of internal claims and Appeals processes – If CareFirst fails to strictly adhere to all the requirements under Timing of Notification of Benefit Determination (Internal claims and Appeal process) with respect to a claim, the Claimant is deemed to have exhausted the internal claims and Appeals process, except as provided in the next paragraph. Accordingly, the

Claimant may initiate an External Review under the External Review Process described below. The Claimant is also entitled to pursue any available remedies under section 502(a) of ERISA on the basis that CareFirst has failed to provide a reasonable internal claims and Appeals process that would yield a decision on the merits of the claim. If a Claimant chooses to pursue remedies under section 502(a) of ERISA under such circumstances, the claim or Appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

Notwithstanding the previous paragraph, the internal claims and Appeals process of this paragraph will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the Claimant so long as CareFirst demonstrates that the violation was for good cause or due to matters beyond the control of CareFirst and that the violation occurred in the context of an ongoing, good faith exchange of information between CareFirst and the Claimant. This exception is not available if the violation is part of a pattern or practice of violations by CareFirst. The Claimant may request a written explanation of the violation from the Plan or the Plan's Designee, and CareFirst must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and Appeals process of this paragraph to be deemed exhausted. If an external reviewer or a court rejects the Claimant's request for immediate review under the previous paragraph on the basis that CareFirst met the standards for the exception under this paragraph, the Claimant has the right to resubmit and pursue the internal Appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed 10 days), CareFirst shall provide the Claimant with Notice of the opportunity to resubmit and pursue the internal Appeal of the claim. Time periods for re-filing the claim shall begin to run upon Claimant's receipt of such Notice.

Manner and Content of Notification of Benefit Determination

- Except in the case of an Adverse Benefit Determination concerning a Claim Involving Urgent Care, CareFirst shall provide a Claimant with written or electronic Notification of any Adverse Benefit Determination. The Notification shall set forth, in a manner calculated to be understood by the Claimant:
  - The specific reason or reasons for the adverse determination;

  - Reference to the specific Plan provisions on which the determination is based;

  - A description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary;

  - A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under Section 502(a) of ERISA following an Adverse Benefit Determination on review;

  - In the case of an Adverse Benefit Determination:

    - If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request; or

    - If the Adverse Benefit Determination is based on a Medical Necessity or Experimental/Investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

  - In the case of an Adverse Benefit Determination by CareFirst concerning a Claim Involving Urgent Care, a description of the expedited review process applicable to such claims.

- In the case of an Adverse Benefit Determination by CareFirst concerning a Claim Involving Urgent Care, the information described above may be provided to the Claimant orally within the time frame prescribed in the procedures noted under Timing of Notification of Benefit Determination herein, provided that a written or electronic Notification in accordance with the procedures noted under Manner and Content of Notification of Benefit Determination in this section is furnished to the Claimant not later than 3 days after the oral Notification.

Appeal of Adverse Benefit Determinations

- To Appeal a denied claim, a written request and any supporting record of medical documentation must be submitted by you or your authorized representative to the following address within 180 days of the Adverse Benefit Determination.

  Central Appeals and Analysis Unit
  P.O. Box 17636
  Baltimore, MD 21297-1636

  - A Claimant has the opportunity to submit written comments, documents, records, and other information relating to the Claim for Benefits;

  - A Claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant to the Claimant's Claim for Benefits.

  - CareFirst shall take into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

- In addition to the requirements described above, the following apply:

  - CareFirst shall provide for a review that does not afford deference to the initial Adverse Benefit Determination and will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the Appeal, nor the subordinate of such individual;

  - In deciding an Appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental/ Investigational, or not Medically Necessary or appropriate, the appropriate named fiduciary shall consult with a Health Care Professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

  - Upon request, CareFirst will identify medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a

Claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination;

- Health Care Professionals engaged for purposes of a consultation shall be individuals who were neither consulted in connection with the Adverse Benefit Determination that is the subject of the Appeal, nor subordinates of any such individuals; and

- In the case of a Claim Involving Urgent Care, a request for an expedited Appeal of an Adverse Benefit Determination may be submitted orally or in writing by the Claimant; and all necessary information, including CareFirst determination on review, may be transmitted between CareFirst and the Claimant by telephone, facsimile, or other available similarly expeditious method.

- Full and fair review – CareFirst shall allow a Claimant to review the claim file and to present evidence and testimony as part of the internal claims and Appeals process. Specifically, in addition to the requirements above, the following apply:

  - CareFirst shall provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by CareFirst (or at the direction of CareFirst) in connection with the claim; such evidence will be provided as soon as possible and sufficiently in advance of the date on which the Notice of Final Internal Adverse Benefit Determination is required to be provided as described under Timing of Notification of Determination of Appeal, to give the Claimant a reasonable opportunity to respond prior to that date; and

  - Before CareFirst issues a Final Internal Adverse Benefit Determination based on a new or additional rationale, the Claimant shall be provided, free of charge, with the rationale; the rationale shall be provided as soon as possible and sufficiently in advance of the date on which the Notice of Final Internal Adverse Benefit Determination is required to be provided as described under Timing of Notification of Determination of Appeal, to give the Claimant a reasonable opportunity to respond prior to that date.

- Avoiding conflicts of interest – In addition to the requirements above regarding full and fair review, CareFirst shall ensure that all claims and Appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly,

decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.

Timing of Notification of Determination of Appeal

- CareFirst shall notify a Claimant of its benefit review in accordance with the following, as appropriate.
  - Urgent care claims -- In the case of a Claim Involving Urgent Care, the Claimant shall be notified, in accordance with the procedures noted under Manner and Content of Notification of Benefit Determination of Appeal herein, of the benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the Claimant's request for review of an Adverse Benefit Determination.
  - Pre-Service Claims – In the case of a Pre-Service Claim, the Claimant shall be notified, in accordance with the procedures noted under Manner and Content of Notification of Benefit Determination of Appeal herein, of the benefit determination on review within a reasonable period of time appropriate to the medical circumstances. Such notification shall be provided no later than 30 days after receipt of the Claimant's request for review of an Adverse Benefit Determination.
  - Post-Service Claims – In the case of a Post-Service Claim, the Claimant shall be notified, in accordance with the procedures noted under Manner and Content of Notification of Benefit Determination of Appeal herein, of the benefit determination on review within a reasonable period of time. Such notification shall be provided no later than 60 days after receipt of the Claimant's request for review of an Adverse Benefit Determination.
- Calculating time periods – For purposes of the procedures noted under Timing of Notification of Determination of Appeal herein, the period of time within which a benefit determination on review shall be made begins at the time an appeal is received by CareFirst, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as permitted pursuant to the procedures noted under "Manner and Content of Notification of Benefit Determination of Appeal," due to a Claimant's failure to submit information necessary to decide a claim, the period for making the

benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information.

- In the case of an Adverse Benefit Determination on review, upon request, CareFirst shall provide such access to, and copies of Relevant documents, records, and other information described in the procedures noted under Manner and Content of Notification of Benefit Determination of Appeal herein as is appropriate.

Manner and Content of Notification of Benefit Determination of Appeal

CareFirst shall provide a Claimant with written or electronic Notification of its benefit determination on review. In the case of an Adverse Benefit Determination, the Notification shall set forth, in a manner calculated to be understood by the Claimant:

- The specific reason or reasons for the adverse determination;

- Reference to the specific Plan provisions on which the benefit determination is based;

- A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant to the Claimant's Claim for Benefits;

- A statement describing any voluntary Appeal procedures offered by the Plan and the Claimant's right to obtain the information about such procedures, and a statement of the Claimant's right to bring an action under Section 502(a) of ERISA; and

  - If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Claimant upon request; and

  - If the Adverse Benefit Determination is based on a Medical Necessity or Experimental/Investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the

determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Notice

- CareFirst shall provide Notice to individuals, in a culturally and linguistically appropriate manner. Additionally:
  - CareFirst shall ensure that any notice of Adverse Benefit Determination or Final Internal Adverse Benefit Determination includes information sufficient to identify the claim involved (including the date of service, the Provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).
  - CareFirst shall provide to a Claimant, as soon as practicable, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, associated with any Adverse Benefit Determination or Final Internal Adverse Benefit Determination. CareFirst shall not consider a request for such diagnosis and treatment information, in itself, to be a request for an internal Appeal under this paragraph or an External Review under the External Review Process.
  - CareFirst shall ensure that the reason or reasons for the Adverse Benefit Determination or Final Internal Adverse Benefit Determination includes the denial code and its corresponding meaning, as well as a description of CareFirst's standard, if any, that was used in denying the claim. In the case of a Notice of Final Internal Adverse Benefit Determination, this description must include a discussion of the decision.
  - CareFirst shall provide a description of available Internal Appeals and External Review processes, including information regarding how to initiate an Appeal.
  - CareFirst shall disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793 to assist individuals with the internal claims and Appeals and External Review processes.

- Form and manner of Notice.
    - In general – For purposes of this section, the Plan is considered to provide Relevant Notices in a culturally and linguistically appropriate manner if CareFirst meets all of the following requirements with respect to the applicable non-English languages described below.
    - Requirements
        - CareFirst shall provide oral language services (such as a telephone customer assistance hotline) that include answering questions in any applicable non English language and providing assistance with filing claims and Appeals (including External Review) in any applicable non-English language;
        - CareFirst shall provide, upon request, a notice in any applicable non-English language; and
        - CareFirst shall include in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by CareFirst.
    - Applicable non-English language. With respect to an address in any United States county to which a Notice is sent, a non-English language is an applicable non-English language if ten percent or more of the population residing in the county is literate only in the same non-English language, as determined in relevant guidance published by the Department of Health and Human Services.

External Review Process

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

U.S. Department of Labor

SUMMARY PLAN DESCRIPTION
As of January 1, 2020

Employee Benefits Security Administration
200 Constitution Avenue, NW
Washington, DC 20210
(866) 444-EBSA (3272)
((866) 487-2365)

Washington District Office
1335 East-West Highway, Suite 200
Silver Spring, Maryland 20910
(202) 693-8700
www.askebsa.dol.gov

- In general, subject to the suspension provision in the next paragraph and except to the extent provided otherwise by the Secretary in guidance, the External Review process described herein applies to any Adverse Benefit Determination or Final Internal Adverse Benefit Determination, except that a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a Claimant fails to meet the requirements for eligibility under the terms of the Plan is not eligible for the External Review process.

- Suspension of general rule – unless or until this suspension is revoked in guidance by the Secretary, with respect to claims for which External Review has not been initiated before September 20, 2011, the External Review process applies only to:

    - An Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by CareFirst that involves medical judgment (including, but not limited to, those based on CareFirst's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a Covered Service; or its determination that a treatment is Experimental/ Investigational), as determined by the External Reviewer; and

    - A Rescission of coverage (whether or not the Rescission has any effect on any particular benefit at that time).

- Standard External Review – Standard External Review is External Review that is not considered expedited (as described below).

    - Request for External Review – The Plan allows a Claimant to file a request for an External Review with CareFirst if the request is filed within four months after the date of receipt of a Notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination. If there is no

corresponding date four months after the date of receipt of such a Notice, then the request must be filed by the first day of the fifth month following the receipt of the Notice. For example, if the date of receipt of the Notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

- Preliminary review – Within five business days following the date of receipt of the External Review request, CareFirst shall complete a preliminary review of the request to determine whether:

  - The Claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;

  - The Adverse Benefit Determination or the final Adverse Benefit Determination does not relate to the Claimant's failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);

  - The Claimant has exhausted the Plan's Internal Appeal process unless the Claimant is not required to exhaust the Internal Appeals process; and

  - The Claimant has provided all the information and forms required to process an External Review.

    Within one business day after completion of the preliminary review, CareFirst shall issue a Notification in writing to the Claimant. If the request is complete but not eligible for External Review, such Notification shall include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such Notification shall describe the information or materials needed to make the request complete and CareFirst shall allow a Claimant to perfect the request for External Review within the four-month filing period or within the 48-hour period following the receipt of the Notification, whichever is later.

- Referral to Independent Review Organization – CareFirst shall assign an Independent Review Organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the External Review. Moreover, CareFirst shall take action against bias and to ensure independence. Accordingly, CareFirst shall contract with at least three IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

  The contract between CareFirst and an IRO, shall include the following:

  - The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the Plan.

  - The assigned IRO will timely notify the Claimant in writing of the request's eligibility and acceptance for External Review. This Notice will include a statement that the Claimant may submit in writing to the assigned IRO within ten business days following the date of receipt of the Notice additional information that the IRO must consider when conducting the External Review. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.

  - Within five business days after the date of assignment of the IRO, CareFirst shall provide to the assigned IRO the documents and any information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Failure by CareFirst to timely provide the documents and information will not delay the conduct of the External Review. If CareFirst fails to timely provide the documents and information, the assigned IRO may terminate the External Review and make a decision to reverse the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Within one business day after making the decision, the IRO shall notify the Claimant and the Plan or CareFirst.

  - Upon receipt of any information submitted by the Claimant, the assigned IRO shall within one business day forward the information to the Plan or CareFirst. Upon receipt of any such information, CareFirst may reconsider its Adverse Benefit Determination or Final Internal Adverse Benefit Determination that is the subject of the

External Review. Reconsideration by CareFirst shall not delay the External Review. The External Review may be terminated as a result of the reconsideration only if the Plan or CareFirst decides, upon completion of its reconsideration, to reverse its Adverse Benefit Determination or Final Internal Adverse Benefit Determination and provide coverage or payment. Within one business day after making such a decision, the Plan or CareFirst shall provide written Notice of its decision to the Claimant and the assigned IRO. The assigned IRO shall terminate the External Review upon receipt of the Notice from CareFirst.

- The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Internal Claims and Appeals process. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:
    - The Claimant's medical records;
    - The attending health care professional's recommendation;
    - Reports from appropriate health care professionals and other documents submitted by CareFirst, Claimant, or the Claimant's treating provider;
    - The terms of the Claimant's Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
    - Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
    - Any applicable clinical review criteria developed and used by CareFirst, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and

  - The opinion of the IRO's clinical reviewer or reviewers after considering the information described in this Notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

- The assigned IRO shall provide written Notice of the final External Review decision within 45 days after the IRO receives the request for the External Review. The IRO shall deliver the Notice of final External Review decision to the Claimant and the Plan or CareFirst.

- The assigned IRO's decision Notice will contain:

  - A general description of the reason for the request for External Review, including information sufficient to identify the claim (including the date or dates of service, the Health Care Provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);

  - The date the IRO received the assignment to conduct the External Review and the date of the IRO decision;

  - References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

  - A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

  - A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Plan or to the Claimant;

  - A statement that judicial review may be available to the Claimant; and

  - Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

- After a final External Review decision, the IRO shall maintain records of all claims and Notices associated with the External Review process for six years. An IRO shall make such records available for examination by the Claimant, Plan, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

- Reversal of Plan's decision – Upon receipt of a Notice of a final External Review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan shall immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Review

- Request for expedited External Review – A Claimant may make a request for an expedited External Review with CareFirst at the time the Claimant receives:

  - An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the Claimant for which the timeframe for completion of an expedited Internal Appeal would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an expedited Internal Appeal;

  - A Final Internal Adverse Benefit Determination, if the Claimant has a medical condition where the timeframe for completion of a standard External Review would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received Emergency Services, but has not been discharged from a facility.

- Preliminary review – Immediately upon receipt of the request for expedited External Review, CareFirst shall determine whether the request meets the reviewability requirements for standard External Review. CareFirst shall immediately send a Notice that meets the requirements for standard External Review to the Claimant of its eligibility determination.

  - Referral to Independent Review Organization – Upon a determination that a request is eligible for External Review following the preliminary review, CareFirst will assign an IRO for standard review. CareFirst shall provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other expeditious method.

    The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, shall consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO shall review the claim de novo and is not bound by any decisions or conclusions reached during the internal claims and Appeals process.

  - Notice of final External Review decision – CareFirst's contract with the assigned IRO shall require the IRO to provide Notice of the final External Review decision as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited External Review. If the Notice is not in writing, within 48 hours after the date of providing that Notice, the assigned IRO shall provide written confirmation of the decision to the Claimant and the Plan or CareFirst.

- An External Review decision is binding on the Plan, as well as the Claimant, except to the extent other remedies are available under State or Federal law, and except that the requirement that the decision be binding shall not preclude the Plan from making payment on the claim or otherwise providing benefits at any time, including after a final External Review decision that denies the claim or otherwise fails to require such payment or benefits. For this purpose, the Plan shall provide any benefits (including by making payment on the claim) pursuant to the final External Review decision without delay, regardless of whether the Plan or CareFirst intends to seek judicial review of the External Review decision and unless or until there is a judicial decision otherwise.

SUMMARY PLAN DESCRIPTION
As of January 1, 2020

GENERAL PLAN PROVISIONS

No Assignment

A covered person cannot assign any benefits or payments due under the Plan to any person, corporation or other organization, except as specifically provided by the Plan or as required by law.

Notwithstanding the foregoing, the Plan may choose to remit payments directly to Providers with respect to Covered Services rendered to you, but only as a convenience to Plan participants. Providers are not, and shall not be construed as, either “participants” or “beneficiaries” under this Plan and have no rights to receive benefits from the Plan under any circumstances.

Plan’s Right to Recover Overpayment

Payments are made in accordance with the provisions of the Plan, including the Plan Document and this Summary Plan Description. If it is determined that payment was made for an ineligible charge or that other insurance was considered primary, the Plan has the right to recover the overpayment. The Plan (or CareFirst) will attempt to collect the overpayment from the party to whom the payment was made. However, the Plan reserves the right to seek overpayment from any participant, beneficiary or dependent. Failure to comply with this request will entitle the Plan to withhold benefits due a participant, beneficiary or dependent. In addition, the Plan has the right to engage an outside collection agency to recover overpayments on the Plan’s behalf if the Plan’s collection effort is not successful.

Payments under the Plan

Payments for Covered Services will be made by CareFirst directly to Preferred Providers. If a covered person receives Covered Services from non-Preferred Providers, CareFirst reserves the right to pay either the covered person or the provider and such payment shall, in either case, constitute full and complete satisfaction of CareFirst’s obligation.

Claim Payments Made in Error

The covered person is liable for any amount paid to a covered person by CareFirst by mistake or in error on behalf of a covered person. If the covered person has not repaid the full amount owed and CareFirst makes a subsequent benefit payment, CareFirst may subtract the amount owed CareFirst from the subsequent payment.

Uncashed Checks

If a check to you for benefits under the Plan remains uncashed for 24 months after the issue date, and if the Plan has not received a request to reissue or void the outstanding check, amounts attributable to such check shall be considered abandoned. In such event, any further claim you may have to such amount shall be subject to applicable state law governing abandoned property.

Identification Card

Any cards issued to a covered person are for identification only.

- Possession of an identification card confers no right to benefits under the Plan.
- To be entitled to such benefits under the Plan, the holder of the card must, in fact, be a covered person on whose behalf all applicable charges have actually been paid.
- Any person receiving benefits to which he or she is not then entitled under the Plan will be liable for the actual cost of such benefits.
- Coverage may be terminated by CareFirst in the event of misuse of the identification cards

Privacy Statement

CareFirst and the Plan shall comply with state, federal and local laws pertaining to the dissemination or distribution of non-public personally identifiable medical or health-related data.

Payments to the Plan

If any third party administrator pays dividends, rebates, demutualization proceeds, or similar payments, such amounts shall be paid to and considered the property of the Plan Sponsor to the extent permitted by law, unless the Plan Sponsor or the Employer elects to contribute such amounts to the Plan.

CareFirst's Relationship to the Company

Washington Gas is not an agent or representative of CareFirst and is not liable for any acts or omissions by CareFirst or any provider. CareFirst is not an agent or representative of Washington Gas and is not liable for any acts or omissions of Washington Gas.

Administration of the Plan

The Plan and/or CareFirst may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of the Plan.

Limitation on Provider Coverage

Services are covered only if the provider is an eligible provider as defined above, is licensed in the jurisdiction in which the services are rendered and if the services are within the lawful scope of the services for which that provider is licensed. Coverage does not include services rendered to a covered person by any individual who is not an eligible provider, as defined above.

Rules for Determining Dates and Times

The following rules will be used when determining dates and times with respect to the Plan:

- All dates and times of day will be based on Eastern Standard Time or Eastern Daylight Saving Time, as applicable.
- When reference is made to coverage being effective on a particular date, this means 12:01 a.m. on that date.
- When reference is made to termination being effective on a particular date, this means 12:00 midnight on that date.
- “Days” mean calendar days, including weekends, holidays, etc., unless otherwise noted.
- “Year” refers to calendar year, unless a different basis is specifically stated.

Notices to Covered Persons

Notices to covered persons required under the Plan shall be in writing directed to the covered person’s last known address. The notice will be effective on the date mailed,

whether or not the covered person receives the notice or there is a delay in receiving the notice.

Provider and Services Information

Listings of current in-network providers are available through CareFirst's website at www.carefirst.com or www.bcbs.com. Sites are updated on a regular basis. You may also contact CareFirst's Member Service at 800-321-3497 for a list of in-network providers.

Plan Amendment and Termination

Washington Gas has the right to amend or terminate the Plan at any time. This reservation of the right to amend or terminate benefits applies to benefits for current employees and their dependents and also to retired or terminated employees and their survivors or dependents. Nothing in this document or other communication from Washington Gas or its delegee with respect to the Plan shall be deemed to create or imply a continuing obligation by Washington Gas to provide or fund benefits to current associates or their dependents or survivors.

All amendments to the Plan shall be in writing, and any oral statements or representations made by any individual or entity that purport to alter, modify, amend, or are inconsistent with the written terms of the Plan shall be invalid and unenforceable and may not be relied upon by any individual or entity.

Applicable Law

The Plan and all rights hereunder are governed by and construed, administered, and regulated in accordance with the provisions of ERISA, HIPAA, and the Internal Revenue Code to the extent applicable, and to the extent not preempted by ERISA, the laws of the Commonwealth of Virginia, without giving effect to its conflicts of laws provision. The Plan may not be interpreted to require any person to take any action, or fail to take any action, if to do so would violate any applicable law.

Discretionary Authority

The plan administrator (and any fiduciary with authority to decide benefit claims) has discretionary authority to interpret the Plan and to resolve any ambiguities under the plan. The plan administrator (or such fiduciary) also has the discretionary authority to make any necessary factual determinations as to whether any individual is entitled to receive any benefits under the Plan.

Legal Action

No legal action may be taken by a covered person based on a denial of a health care claim unless: (1) the covered person has exhausted the Internal Claims and Appeal Process under these Claims Procedures and (2) such legal action is filed within one year of the date of the issuance of the final denial of the covered person's health care claim.

Plan Continuation

Washington Gas expects and intends to continue these benefits indefinitely, but reserves the right to amend or terminate the Plan at any time, for any lawful reason without notice with respect to any covered retirees and their eligible dependents. If the Plan is amended or terminated, you and others may not receive benefits as described in other sections of this summary plan description. You may be entitled to receive different benefits, or other benefits under different conditions. However, it is possible that you will lose all benefit coverage. This may happen at any time if the Plan is terminated, your coverage under the Plan is terminated, or your Employer is an adopting Employer and withdraws from participation in the Plan. In no event will you become entitled to any vested rights under this Plan. If coverage ends and is not replaced by similar coverage, you will be informed if any conversion rights apply.

SUMMARY PLAN DESCRIPTION
As of January 1, 2020

DEFINITIONS

In addition to the previously defined terms, the description of Covered Services uses certain other defined terms. These are generally defined in the section in which they first appear. The following general terms are also used:

- **Allowed Benefit** means:

For a Preferred Provider, the Allowed Benefit for a Covered Service is the lesser of the actual charge which, in some cases, will be a rate set by a regulatory agency, or the amount CareFirst allows for the service in effect on the date the service is rendered. The benefit is payable to the provider and is accepted as payment in full, except for any applicable deductible, copayment and coinsurance amounts, for which the covered person is responsible.

For a Non-Preferred Provider, the Allowed Benefit for a Covered Service is based upon the lesser of the Provider's actual charge or established fee schedule which, in some cases, will be a rate specified by applicable law. The benefit is payable to the covered person or to the provider, at the discretion of CareFirst. The covered person is responsible for any applicable deductible, copayment, and coinsurance amounts and for the difference between the Allowed Benefit and the practitioner's actual charge. For more information on the Allowed Benefit, please contact CareFirst at (800) 628-8549 or log into your account at http://www.carefirst.com.

For a Non-Preferred Facility, the Allowed Benefit for a Covered Service is based upon either the provider's actual charge or established fee schedule, which, in some cases, will be a rate specified by applicable law. In some cases, and on an individual basis, CareFirst is able to negotiate a lower rate with an eligible provider, in which case 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 and coinsurance amounts, for which the covered person is responsible. The benefit is payable to the covered person or to the facility, at the discretion of CareFirst. The covered person is responsible for any applicable deductible, copayment, and coinsurance amounts and, unless negotiated, for the difference between the Allowed Benefit and the hospital or health care facility's actual charge. For more information on the Allowed Benefit, please contact CareFirst at (800) 628-8549 or log into your account at http://www.carefirst.com.

For Emergency Services received from a Non-Preferred Provider or Facility, the Allowed Benefit for the Emergency Services received is the greater of the following:

- The Allowed Benefit for a Non-Preferred Provider or Facility, as described above (as applicable);

- The amount negotiated with Preferred Providers for the Emergency Service provided, excluding any Copayment or Coinsurance that would be imposed if the service had been received from a contracted Emergency Services Provider. If there is more than one amount negotiated with Preferred Providers for the Emergency Service provided, the amount paid shall be the median of these negotiated amounts, excluding any Copayment or Coinsurance that would be imposed if the service had been received from a contracted Emergency Services Provider;

- The amount for the Emergency Service calculated using the same method CareFirst generally uses to determine payments for services provided by a Non-Preferred Provider, excluding any Copayment or Coinsurance that would be imposed if the service had been received from a contracted Emergency Services Provider; and

- The amount that would be paid under Medicare for the Emergency Service, excluding any Copayment or Coinsurance that would be imposed if the service had been received from a contracted Emergency Services Provider.

- **Ancillary Services** means facility services that may be rendered on an inpatient and/or outpatient basis. These services include, but are not limited to, diagnostic and therapeutic services such as laboratory, radiology, operating room services, incremental nursing services, blood administration and handling, pharmaceutical services, Durable Medical Equipment and Medical Supplies. Ancillary Services do not include room and board services billed by a facility for inpatient care.

- **Benefit Period** means the period of time during which Covered Services are eligible for payment. The Benefit Period is January 1st through December 31st.

- **Convenience Item** means any item that increases physical comfort or convenience without serving a Medically Necessary purpose, e.g. elevators, foyer/stair lifts, ramps, shower/bath bench, items available without a prescription.

- **Cosmetic** means the use of 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 Service** means a Medically Necessary service or supply provided in accordance with the terms of this Summary Plan Description.

- **Deductible** means the dollar amount of Covered Services based on the Allowed Benefit, which must be incurred before the Plan will pay for all or part of remaining Covered Services. The Deductible is met when the covered person receives Covered Services that are subject to the Deductible and pays for these him/herself.

- **Designated Provider** means a provider or vendor contracted with CareFirst to provide services under CareFirst's Care Support Programs, and who has agreed to participate in Care Support Programs in cooperation with CareFirst for covered persons with complex chronic disease, high risk acute conditions or lifestyle behavior change.

- **Experimental/Investigational** means a service or supply that is in the developmental stage and in the process of human or animal testing excluding Controlled Clinical Trial Patient Cost Coverage as described in this Summary Plan Description. Services or supplies that do not meet all of the following criteria are deemed to be Experimental/Investigational:

    - The technology (including drugs, devices, processes, systems, or techniques) must have final approval from the appropriate government regulatory bodies;

    - The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes;

    - The technology must improve the net health outcome;

    - The technology must be as beneficial as any established alternatives; and

    - The improvement must be attainable outside the Investigational settings.

- **Infusion Therapy** means treatment that places therapeutic agents into the vein, including intravenous feeding.

- **Lifetime Maximum** means the maximum dollar amount payable toward a covered person's claims for Covered Services while the covered person is covered under this Plan.

- **Medically Necessary or Medical Necessity** 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 and which are (1) in accordance with generally accepted standards of medical practice, (2) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for a patient's illness, injury or disease, (3) not primarily for the convenience of a patient or Provider, and (4) 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. "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 views of Providers practicing in relevant clinical areas, and any other relevant factors.

- **Non-Preferred Provider** means a Provider that is not a Preferred Provider.

- **Occupational Therapy** means the use of purposeful activity or interventions designed to achieve functional outcomes that promote health, prevent injury or disability, and that develop, improve, sustain or restore the highest possible level of independence of an individual who has an injury, illness, cognitive impairment, psychosocial dysfunction, mental illness, developmental or learning disability, physical disability, loss of a body part, or other disorder or condition.

- **Out-of-Pocket Maximum** means the maximum amount a covered person will have to pay for his/her share of benefits in any Benefit Period.

- **Over-the-Counter** means any item or supply, as determined by CareFirst, that is available for purchase without a prescription.

- **Physical Therapy** means the short-term treatment of disease or injury through the use of therapeutic exercise and other interventions that focus on improving a person's ability to go through the functional activities of daily

living, to develop and/or restore maximum potential function, and to reduce disability following an illness, injury or loss of a body part and which can be expected to result in an improvement of a condition.

- **Plan of Treatment** means the plan written and given to CareFirst by the attending Provider on CareFirst forms which shows the covered person's diagnoses and needed treatment.

- **Preferred Provider** means a Provider who contracts with CareFirst to be paid directly for rendering Covered Services to covered persons. A listing of Preferred Providers is available from CareFirst upon request without charge. The listing of Preferred Providers is subject to change. Covered persons may confirm the status of any provider prior to making arrangements to receive care by contacting CareFirst for up-to-date information.

- **Prescription Drug**, for purposes of the Description of Covered Services, means (1) a drug, biological, or compounded prescription intended for outpatient use that carries the U.S. Food and Drug Administration legend "may not be dispensed without a prescription", (2) drugs prescribed for treatments other than those stated in the labeling approved by the U.S. Food and Drug Administration, if the drug is recognized for such treatment in standard reference compendia or in the standard medical literature as determined by CareFirst, (3) Over-the-Counter medication or supply, if Over-the-Counter medications or supply are Covered Services under the Plan, and (4) Diabetic Supplies. Prescription Drugs do not include (1) compounded bulk powders that contain ingredients that do not have U.S. Food and Drug Administration approval for the route of administration being compounded, have no clinical evidence demonstrating safety and efficacy, or do not require a prescription to be dispensed, or (2) compounded drugs that are available as a similar commercially available Prescription Drug unless there is no commercially available bio-equivalent Prescription Drug or the commercially available bio-equivalent has caused or is likely to cause the covered person to have an adverse reaction.

- **Private Duty Nursing** means Skilled Nursing Care services, ordered by a Provider, that can only be provided by a licensed health care professional.

- **Provider** means a hospital, health care facility, or health care practitioner licensed or otherwise authorized by law to provide Covered Services.

- **Rehabilitative Services** include Physical Therapy, Occupational Therapy, and Speech Therapy for the treatment of individuals who have sustained an illness. The goal of rehabilitative services is to return the individual to his/her prior skill and functional level.

- **Service Area** means CareFirst's Service Area, a clearly defined geographic area in which CareFirst has arranged for the provision of health care services to be generally available and readily accessible to covered persons.

- **Skilled Nursing Care**, when provided in the home, means Medically Necessary skilled care services performed in the home, by a licensed registered nurse (RN) or licensed practical nurse (LPN). Skilled nursing care visits must be a substitute for hospital care or for care in a Skilled Nursing Facility (i.e., if visits were not provided, a covered person would have to be admitted to a hospital or Skilled Nursing Facility). Services of a home health aide, medical social worker or registered dietician may also be provided but must be performed under the supervision of a licensed professional (RN or LPN) nurse. Skilled Nursing Care, when provided in an inpatient hospital/facility or Skilled Nursing Facility, means care for medically fragile covered persons with limited endurance who require a licensed health care professional to provide skilled services in order to ensure the covered person's safety and to achieve the medically desired result, provided on a 24-hour basis, seven days a week. Skilled Nursing Care is not Medically Necessary if the proposed services can be provided by a caregiver or the caregiver can be taught and demonstrates competency in the administration of same. Performing the activities of daily living, including, but not limited to, bathing, feeding, and toileting is not Skilled Nursing Care.

- **Skilled Nursing Facility** means a licensed institution (or a distinct part of a hospital) that provides continuous Skilled Nursing Care or Rehabilitative Services.

- **Speech Therapy** means the treatment of communication impairment and swallowing disorders. It facilitates the development and maintenance of human communication and swallowing through assessment, diagnosis, and rehabilitation.

- **Substance Use Disorder** means a disease that is characterized by a pattern of pathological use of alcohol or a drug 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.

- **Substance Use Disorder Program** means the program described herein for covered persons with a diagnosed Substance Use Disorder. The program includes ambulatory/outpatient detoxification, individual therapy, group therapy and medication assisted therapy.

SUMMARY PLAN DESCRIPTION
As of January 1, 2020

INTER-PLAN ARRANGEMENTS

CareFirst has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access healthcare services outside the geographic area CareFirst serves, the claim for those services may be processed through one of these Inter-Plan Programs. The Inter-Plan Programs are described generally below.

When you receive care outside of CareFirst's Service Area, it will be received from one of two kinds of providers. Most providers ("participating providers") contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue"). Some providers ("nonparticipating providers") don't contract with the Host Blue. Below is an explanation of how CareFirst pays both kinds of providers.

Some CareFirst products limit in-network benefits to certain services and/or cover only limited healthcare services received outside of CareFirst's Service Area, such as Emergency Services. If applicable, any difference between benefits for care received in CareFirst's Service Area and care received outside the geographic area CareFirst serves is stated in this SPD.

All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for dental care, and prescription drug or vision benefits that may be administered by a third party contracted by CareFirst to provide the specific service or services. The claim types are described below:

BlueCard Program – Under the BlueCard® Program, when you receive Covered Services within the geographic area served by a Host Blue, CareFirst will remain responsible for doing what it agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating providers.

When you receive Covered Services outside CareFirst's Service Area and the claim is processed through the BlueCard Program, the amount you pay for Covered Services is calculated based on the lower of:

- The billed charges for Covered Services; or
- The negotiated price that the Host Blue makes available to CareFirst.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with the healthcare provider or provider group that

may include types of settlements, incentive payments and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct for over or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price CareFirst has used for a claim because they will not be applied after a claim has already been paid.

Negotiated (non-BlueCard Program) Arrangements – With respect to one or more Host Blues, instead of using the BlueCard Program, CareFirst may process claims for Covered Services through negotiated arrangements for national Accounts.

The amount that you pay for Covered Services under this arrangement will be calculated based on the lower of either billed charges for Covered Services or negotiated price (as described above under “BlueCard Program”) made available to CareFirst by the Host Blue.

If reference-based benefits, which are service-specific benefit dollar limits for specific procedures, based on a Host Blue’s local market rates, are made available to you, you will be responsible for the amount that the healthcare provider bills above the specific reference benefit limit for the given procedure. For an in-network provider, that amount will be the difference between the negotiated price and the reference benefit limit. For an out-of-network provider, that amount will be the difference between the provider’s billed charge and the reference benefit limit. Where a reference benefit limit is greater than either a negotiated price or a provider’s billed charge, you will incur no liability, other than any related cost sharing.

Special Cases: Value-Based Programs

- *BlueCard Program.* If you receive Covered Services under a value-based program inside a Host Blue’s service area, you will not be responsible for paying any of the provider incentives, risk-sharing, and/or care coordinator fees that are a part of such an arrangement, except when a Host Blue passes these fees to CareFirst through average pricing or fee schedule adjustments. Additional information is available upon request.

- *Value-Based Programs: Negotiated (non-BlueCard Program) Arrangements.* If CareFirst has entered into a negotiated arrangement with a Host Blue to provide value-based programs to the Plan on your behalf, CareFirst will follow the same

procedures for value-based programs administration and care coordinator fees as noted above for the BlueCard Program.

Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees – Federal or state laws or regulations may require a surcharge, tax or other fee that applies to self-funded accounts. If applicable, CareFirst will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

Out-of-Network Providers Outside CareFirst's Service Area

- *Covered Person Liability Calculation.* When Covered Services are provided outside of CareFirst's Service Area by out-of-network providers, the amount you pay for such services will normally be based on either the Host Blue's out-of-network provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be responsible for the difference between the amount that the out-of-network provider bills and the payment CareFirst will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

- *Exceptions.* In certain situations, CareFirst may use other payment methods, such as billed charges for Covered Services, the payment CareFirst would make if the healthcare services had been obtained within CareFirst's Service Area, or a special negotiated payment to determine the amount CareFirst will pay for services provided by out-of-network providers. In these situations, you may be liable for the difference between the amount that the out-of-network provider bills and the payment CareFirst will make for the Covered Services as set forth in this paragraph.

Blue Cross Blue Shield Global Core Program – If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard service area"), you may be able to take advantage of the Global Core Program when accessing Covered Services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although Blue Cross Blue Shield Global Core assists you with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the BlueCard service area, you will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week. An assistance

coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

- *Inpatient Services.* In most cases, if you contact the Blue Cross Blue Shield Global Core Service Center for assistance, hospitals will not require you to pay for covered inpatient services, except for cost-share amounts. In such cases, the hospital will submit your claim to the service center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for Covered Services. **You must contact CareFirst to obtain precertification for non-emergency inpatient services.**

- *Outpatient Services.* Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for Covered Services.

- *Submitting a Blue Cross Blue Shield Global Core Claim.* When you pay for Covered Services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global Core claim form and send the claim form with the provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of the claim. The claim form is available from CareFirst, the service center or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week.

Inter-Plan Programs Ancillary Services

For purposes of this section:

- **Ancillary Services** means, with respect to Inter-Plan Programs, the following Covered Services:
    - Independent clinical laboratory tests (performed at non-hospital-based laboratories); and
    - Medical Devices and Supplies.

- **Contracted Health Care Provider** means, for purposes of this "Inter-Plan Ancillary Services" section, a Provider that has contracted with the local Blue Cross and/or Blue Shield Licensee (not CareFirst) and provides Ancillary Services to the covered person outside of the CareFirst Service Area, as stated herein.

- **Non-Contracted Health Care Provider** means, for purposes of this "Inter-Plan Ancillary Services" section, a Provider that does not contract with the local Blue Cross and/or Blue Shield Licensee (not CareFirst) and provides Ancillary Services to the Member outside of the CareFirst Service Area, as stated herein**.**

- **Remote Provider** means, with respect to Ancillary Services an Ancillary Service provider located outside the geographic area a Blue Cross and/or Blue Shield plan serves, with which a Blue Cross and/or Blue Shield plan may contract under its Blue Cross and Blue Shield Association license agreement for Ancillary Services rendered in its service area and which are considered local providers.

Member payment for Ancillary Services is determined by the relationship between the provider and the local plan (which may be CareFirst).

If an Ancillary Services Remote Provider contract is in place with the local plan, the Remote Provider is a Contracted Provider or a Provider who contracts with the local Blue Cross and/or Blue Shield Licensee in that geographic area as stated in this "Inter-Plan Arrangements" section.

If an Ancillary Services Remote Provider contract is not in place with the local plan, the Remote Provider is a Non-Contracted Provider / non-participating Provider.

The covered person is responsible for the covered person payment as stated in "How the PPO Program Works" or "Inter-Plan Arrangements" section of this SPD.

For Ancillary Services, the local plan is determined as follows:

Out-of-Network Covered Ancillary Service	The local plan is the Blue Cross/Blue Shield plan in whose service area/state where the:	
Independent clinical laboratory tests	Specimen was drawn, if the referring provider is located in the same service area.	Referring provider is located, if the provider is not located in the same service area where the specimen was drawn.
Medical Devices and Supplies	Medical Devices and/or Supplies were: • Shipped to; or • Purchased at a retail store	

SUMMARY PLAN DESCRIPTION
As of January 1, 2020

UTILIZATION MANAGEMENT REQUIREMENTS

IMPORTANT

FAILURE TO MEET THE REQUIREMENTS OF THE UTILIZATION MANAGEMENT PROGRAM MAY RESULT IN A REDUCTION OR DENIAL OF COVERAGE EVEN IF THE SERVICES ARE OTHERWISE MEDICALLY NECESSARY.

Before certain services will be covered they will be subject to review and approval under utilization management requirements established by the Plan. Through utilization management, CareFirst reviews a covered person's care and evaluates requests for approval of coverage to assess the medical necessity for the services, the appropriateness of the hospital or facility requested, and the appropriate length of confinement or course of treatment. This assessment will be made in accordance with established criteria.

In addition, utilization management may include second surgical opinion and/or pre-admission testing requirements, concurrent review discharge planning and case management. Failure or refusal to comply with notice requirements and other utilization management authorization and approval procedures will result in the denial of or significant reduction in benefits.

CareFirst will provide additional information regarding utilization management requirements and procedures, including telephone numbers and hours of operation, at any time upon request. For questions regarding utilization management requirements, please call the toll free number for pre-certification on the back of the covered person's identification card.

Prior authorization applies to most Specialty Drugs covered under the medical portion of this Summary Plan Description (i.e., Specialty Drugs administered in outpatient facilities, home, or office settings). Preferred Providers located in the Service Area will obtain prior authorization on behalf of the covered person. Covered Ancillary Services that use Specialty Drugs which require prior authorization do not require an additional prior authorization / a Plan of Treatment. **Specialty Drugs** are Prescription Drugs which include, but are not limited to, drugs that are high cost, large molecule, with high potential for adverse effects, have stability concerns requiring special handling, and/or are often derived from biologic processes rather than chemical processes.

Failure to obtain prior authorization may result in denial of the claim.

Plan of Treatment

Certain outpatient services indicated throughout this SPD require approval of a Plan of Treatment before benefits are provided; a penalty may apply if such approval is not obtained.

A health care practitioner must complete and submit a Plan of Treatment, and CareFirst must approve the Plan of Treatment before benefits for treatment can begin or continue. Approval for coverage of any service is based on Medical Necessity as determined by CareFirst. Within the Service Area, a Preferred Provider will complete and submit a Plan of Treatment. Outside the Service Area, the Member is responsible for ensuring that the Plan of Treatment is submitted to CareFirst by a Provider, regardless of whether the provider is a Preferred Provider or a Non-Preferred Provider.

CareFirst must approve a Plan of Treatment for the following:

- Autism Spectrum Disorders
- Controlled Clinical Trial Patient Cost coverage
- General anesthesia and associated hospital or ambulatory facility charges in conjunction with dental care
- Hospice Care
- Infertility Services: Artificial Insemination
- Infertility Services: In-Vitro Fertilization

If the Plan of Treatment for the above is not submitted, benefits will be denied. If the Plan of Treatment is submitted after commencing services for the above, the same level of benefits will be provided for Covered Services upon CareFirst's approval of the Plan of Treatment, as if the Plan of Treatment had been submitted on time. In addition to the above, with respect to Covered Services related to Autism Spectrum Disorders, CareFirst must approve a Plan of Treatment after the first visit ("Initial Visit"). If a covered person requires additional treatment after the initial Plan of Treatment is completed, a subsequent Plan of Treatment is required prior to the first visit. That is, the Initial Visit(s) exemption from the Plan of Treatment requirement stated above, is only available once per lifetime, per covered person, while covered by CareFirst.

Hospital Pre-Certification and Review

A Preferred Provider will obtain hospital pre-certification and review. The covered person is responsible for ensuring that a Non-Preferred Provider obtains hospital pre-certification and review. CareFirst may perform the review or may appoint a review agent. The telephone number for obtaining review is printed on the back of the membership card.

Hospital pre-certification and review is not applicable to maternity admissions and admissions for cornea and kidney transplants.

Non-Emergency (Elective) Admissions

The covered person must provide any written information requested by the reviewer at least twenty-four (24) hours prior to the admission. The reviewer will make an initial determination within two working days of receipt of the information necessary to make the determination and will notify the provider and the member.

Emergency (Non-Elective) Admissions

The covered person, the provider, or another person acting on behalf of the covered person must notify the reviewer within twenty-four (24) hours following the covered person's admission, or as soon thereafter as reasonably possible.

The reviewer may not render an adverse decision or deny coverage for Medically Necessary covered benefits solely because the hospital did not notify the reviewer of the emergency admission within twenty-four (24) hours if the covered person's medical condition prevented the hospital from determining the covered person's insurance status and the reviewer's emergency admission notification requirements.

For an involuntary or voluntary inpatient admission of a covered person determined by his or her physician or psychologist, in conjunction with a member of the medical staff of the hospital who has privileges to admit patients to be in imminent danger to self or others, the reviewer may not render an adverse decision during the first twenty-four (24) hours the covered person is in an inpatient facility or until the reviewer's next business day, whichever is later.

The hospital shall immediately notify the reviewer that a covered person has been admitted and shall state the reasons for the admission.

The reviewer will make all initial determinations on whether to approve a nonelective admission within one working day of receipt of the information necessary to make the determination and shall promptly notify the attending provider of the determination.

Continued Stays and Discharges

The reviewer will make all determinations on whether to approve continuation of an admission within one working day of receipt of the information necessary to make the determination and shall promptly notify the attending provider of the determination.

The reviewer will coordinate referrals for discharge planning activities if, in the discretion of the reviewer, a need for such coordination is indicated.

Program Monitoring

The covered person's medical record will be reviewed by the reviewer. The hospital may be requested to evaluate the medical records and respond to the reviewer if there is a delay in which care is not provided when ordered or otherwise requested by a provider in a timely fashion or other delay.

Notice and Appeals

Written notice of an adverse decision will be sent to the provider and the covered person. The provider or the covered person may appeal in writing to CareFirst pursuant to the claims procedures described in this Summary Plan Description. If the attending provider believes the adverse decision warrants immediate reconsideration, the provider may seek a reconsideration of the adverse decision by telephone within 24 hours of request.

SUMMARY PLAN DESCRIPTION
As of January 1, 2020

DESCRIPTION OF COVERED MEDICAL SERVICES

PHYSICIAN AND PROVIDER SERVICES

Preventive and Wellness Services

The Plan provides a benefit for evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF).

- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. The current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.

- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention with respect to the individual involved.

- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

If a recommendation or guideline for a recommended preventive service does not specify the frequency, method, treatment, or setting for the provision of that service, CareFirst will use reasonable medical management techniques to determine any coverage limitations for which a recommended preventive service will be available without cost-sharing requirements to the extent not specified in a recommendation or guideline.

A comprehensive list of the preventive services for children and adults that are covered at no cost to you is available through CareFirst's website at www.carefirst.com. You may also contact CareFirst's Member Service at 800-628-8549 for a copy of the list of preventive services that are covered under the Plan.

The Plan will update new recommendations to the preventive benefits listed above at the schedule established by the Secretary of Health and Human Services.

Maternity Services and Newborn Care

The Plan covers the following maternity services:

- Preventive prenatal services as follows:
  - Outpatient obstetrical care of an uncomplicated pregnancy, including pre-natal evaluation and management office visits, one (1) post-partum office visit, and breastfeeding support, supplies and consultation as provided in the comprehensive guidelines for women's preventive health supported by the Health Resources and Services Administration; and
  - Prenatal laboratory diagnostic tests and services related to the outpatient care of an uncomplicated pregnancy, including those identified in the current recommendations of the United States Preventive Services Task Force that have in effect a rating of "A" or "B" or provided in the comprehensive guidelines for women's preventive health supported by the Health Resources and Services Administration.
- Other outpatient obstetrical care and professional services for all prenatal, delivery and post-partum complications, including, but not limited to, prenatal and postpartum office visits not specifically identified above, and Ancillary Services provided during those visits. These benefits include Medically Necessary laboratory diagnostic tests and services not identified above, but are not limited to, ultrasound services, fetal stress and non-stress tests, and amniocentesis; and
- Professional services rendered during a covered hospitalization for an uncomplicated delivery of the child(ren) or for pregnancy-related complications or complications during delivery, including delivery via caesarian section, if the covered person delivers during that episode of care, and all Ancillary Services provided during such an event.

The Plan covers newborn care services as follows:

- Medically Necessary services for the normal newborn (an infant born at approximately forty (40) weeks gestation who has no congenital or comorbid conditions including but not limited to neonatal jaundice) including the admission history and physical, and discharge examination;
- Medically Necessary inpatient/outpatient Provider services for a newborn with congenital or comorbid conditions; and
- Circumcision.

Inpatient hospital services in connection with childbirth, for the mother or newborn child(ren), including routine nursery care of the newborn child(ren), are available for:

- A minimum of:
    - forty-eight (48) hours following an uncomplicated vaginal delivery;
    - ninety-six (96) hours following an uncomplicated cesarean section.

The Plan also covers the following additional maternity and newborn care services:

- Elective abortions.
- Coverage is available for victims of rape or incest. Benefits are available for pregnancy, including termination of pregnancy, following an act of rape for any female covered person (including a dependent) which was reported to the police within seven days following its occurrence. The seven-day requirement shall be extended to one-hundred and eighty (180) days in the case of an act of rape or incest of a female covered person under thirteen (13) years of age.
- Birthing classes: one course per pregnancy at a CareFirst approved facility.
- Birthing centers.
- Benefits are available for universal hearing screening of newborns provided by a hospital before discharge or in an office or other outpatient setting.
- Benefits are available for comprehensive lactation support and counseling, by a Provider during the pregnancy and/or in the post-partum period, and breastfeeding supplies and equipment.

Maternity services are available to all female covered persons.

Newborn care services and inpatient hospital services for newborn child(ren), including routine nursery care of the newborn child, are not available for the newborn child of a dependent child (i.e., a grandchild), unless grandchildren are eligible for dependent coverage.

Infertility Services

The Plan covers the following infertility services:

- Artificial Insemination/Intrauterine Insemination (AI/IUI)
    - Benefits are available for the diagnosis and treatment of Infertility including Medically Necessary, non-Experimental/Investigational AI/IUI, as follows.
        - Benefits are available when the covered person and the covered person's partner have a history of inability to conceive after one year of unprotected vaginal intercourse, and the covered person has had a fertility examination that resulted in a physician's recommendation of AI/IUI. Benefits for the cost of donor oocytes are not available, nor are benefits for the cost of donor sperm.
    - References in this subsection to a "partner" mean any individual as determined by the Plan.
- In-Vitro Fertilization (IVF)
    - Benefits are available for the diagnosis and treatment of Infertility including Medically Necessary, non-Experimental/Investigational IVF, as follows.
        - Benefits are available when the covered person and the covered person's partner have a history of involuntary Infertility which may be demonstrated by a history of:
            - The Infertility is associated with any of the following medical conditions:
                - Endometriosis;
                - Exposure in utero to diethylstilbestrol, commonly known as DES;
                - Blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy), or
                - Abnormal male factors, including oligospermia, contributing to the infertility.
            - Benefits for the cost of donor oocytes are not available.

        - Benefits for the cost of donor sperm are not available.

    - The covered person has not been able to attain a successful pregnancy through a less costly infertility treatment for which coverage is available; and

    - The IVF procedures are performed at medical facilities that conform to applicable guidelines or minimum standards issued by the American College of Obstetricians and Gynecologists or the American Society for Reproductive Medicine.

  - References in this subsection to a "partner" means any individual as determined by the Plan.

Infertility means the inability to conceive under the conditions determined above.

The following exclusions apply to AI/IUI benefits:

- No AI/IUI benefits are available when the covered person or the covered person's partner has undergone elective sterilization with or without reversal.

- No AI/IUI benefits are available when a surrogate or gestational carrier is used.

- No AI/IUI benefits are available when the service involves the use of donor embryo(s).

- No benefits are available for the cryopreservation, storage, and/or thawing of sperm, oocytes, or embryo(s) related to AI/IUI.

- No benefits are available for the cost of donor oocytes.

- No benefits are available for the cost of donor sperm.

- For AI/IUI, benefits will not be provided for any self-administered fertility drug (including Over-the-Counter medications) that are not listed as a Covered Service in the description of Covered Services.

The following exclusions apply to IVF benefits:

- No IVF benefits are available when the covered person or the covered person's partner has undergone elective sterilization with or without reversal.

- No IVF benefits are available when a surrogate or gestational carrier is used.

- No IVF benefits are available when the service involves the use of donor embryo(s).

- No benefits are available for the cryopreservation, storage, and/or thawing of sperm, oocytes, or embryo(s) related to IVF.

- No benefits are available for the cost of donor oocytes.

- No benefits are available for the cost of donor sperm.

- For IVF, benefits will not be provided for any self-administered fertility drug (including Over-the-Counter medications) that are not listed as a Covered Service in the description of Covered Services.

Coverage for AI/IUI and IVF is limited to a combined $20,000 Lifetime Maximum. See Schedule of Benefits.

Inpatient/Outpatient Provider Services (Ambulatory Services, Hospitalization, Laboratory Services)

The Plan covers the following inpatient/outpatient Provider services:

- Inpatient medical care and consultations.

- Outpatient medical care and consultation, including Telemedicine Services:

  Benefits are available for the use of interactive audio, video, or other electronic media for the purpose of diagnosis, consultation, or treatment of the covered person at a site other than the site where the covered person is located ("Telemedicine Services"). Benefits are available for services appropriately provided through Telemedicine Services, to the same extent as benefits provided for face-to-face consultation or contact between a Provider and a covered person. Telemedicine Services do not include an audio-only telephone, electronic mail message, or facsimile transmission between a Provider and a covered person.

- Support services including room and board in a semi-private room (or in a private room when Medically Necessary), and medical and nursing services provided to hospital patients in the course of care including services such as laboratory, radiology, pharmacy, Occupational Therapy, Physical Therapy, Speech Therapy, blood products (both derivatives and components) and whole blood, if not donated or replaced. See the Schedule of Benefits to determine if benefits are available for a private room and board for non-isolation purposes.

  Inpatient hospital services in connection with a vaginal hysterectomy are available for a minimum of:

  - Not less than twenty-three (23) hours for a laparoscopy-assisted vaginal hysterectomy;

  - Not less than forty-eight (48) hours for a vaginal hysterectomy.

  If the attending provider in consultation with the covered person determines that a shorter period of hospital stay is appropriate, the covered person may stay less than the minimum hospital stay described above.

- Inpatient and outpatient surgery, as follows:

  - Medically Necessary surgical procedures, as determined by CareFirst.

  - Reconstructive surgery. Benefits for reconstructive surgery are limited to surgical procedures that are Medically Necessary, as determined by CareFirst and operative procedures performed on structures of the body to improve or restore bodily function or to correct a deformity resulting from disease, trauma or previous therapeutic intervention.

  - Oral surgery, limited to:

    - Surgery involving a bone, joint or soft tissue of the face, neck or head to treat a condition caused by disease, or congenital deformity not solely involving teeth.

    - Surgery involving a bone, joint, or soft tissue of the face, neck or head to treat a condition caused by accidental injury and trauma, as follows.

      - In the event there are alternative procedures that meet generally accepted standards of professional care for a

covered person's condition, benefits will be based upon the lowest cost alternative.

- Coverage will be provided to repair or replace Sound Natural Teeth that have been damaged or lost due to injury if:
  - The injury did not arise while or as a result of biting or chewing; and
  - Treatment is commenced within six (6) months of the injury.
- Benefits are limited to restoration of the tooth or teeth or the initial placement of a bridge or denture to replace the tooth or teeth injured or lost as a direct and sole result of the accidental bodily injury.

Sound Natural Teeth include 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 (fixed or removable bridges, or dentures).

- Inpatient surgical assistant if the surgery requires surgical assistance as determined by CareFirst.
- Outpatient surgical assistant if the surgery requires surgical assistance as determined by CareFirst.
- Inpatient anesthesia services by a Provider other than the operating surgeon.
- Outpatient anesthesia services by a Provider other than the operating surgeon.
- Inpatient chemotherapy.
- Outpatient chemotherapy, Prescription Drugs benefits for orally administered chemotherapy are available as stated in the Prescription Drugs (Non-Pharmacy) section of this Description of Covered Medical Services.
- Outpatient Infusion Therapy, including Infusion Therapy in the home.

- Inpatient inhalation therapy.
- Outpatient inhalation therapy.
- Inpatient radiation therapy.
- Outpatient radiation therapy.
- Inpatient renal dialysis.
- Outpatient renal dialysis.
- Inpatient diagnostic services, including laboratory tests, x-ray and radiology services, and diagnostic specialty imaging and other diagnostic services.
- Outpatient diagnostic services, including laboratory tests, x-ray and radiology services, and diagnostic specialty imaging and other diagnostic services.
- Administration of injectable prescription drugs by a Provider.
- Acupuncture.
- Allergen immunotherapy (allergy injections), allergenic extracts (allergy sera), and allergy testing.
- Contraceptive exam, insertion and removal: benefits are available for the insertion or removal, and any Medically Necessary examination associated with the use of a contraceptive device, approved by the U.S. Food and Drug Administration for use as a contraceptive, and prescribed by a Provider.
- Inpatient or outpatient benefits for cleft lip or cleft palate or both, as follows:
  - Oral surgery.
  - Orthodontics.
  - Otologic, audiological and speech/language treatment.
- Female elective sterilization.
- Male elective sterilization.

- Procedures to reverse sterilization.
- Skilled Nursing Facility services.
- Spinal manipulation, limited to Medically Necessary spinal manipulation, evaluation and treatment for the musculoskeletal conditions of the spine when provided by a qualified chiropractor or doctor of osteopathy (D.O.). Benefits will not be provided for spinal manipulation services other than for musculoskeletal conditions of the spine.
- Treatment of temporomandibular joint (TMJ) dysfunction: Medically Necessary conservative treatment and surgery, as determined by CareFirst.
- Family planning services, including contraceptive counseling.
- Outpatient hearing care, as follows:
    - Screening examination to diagnose hearing loss.
    - Medically Necessary audiometric testing by a physician or an audiologist, if the physician who performs a screening exam refers the covered person to an audiologist.

The Plan will not provide a benefit for:

- Medical care for inpatient stays that are primarily for observation.
- Medical care for inpatient stays that are primarily for diagnostic services.
- Medical care for inpatient stays that are primarily for Rehabilitative Services, except as stated in the description of Covered Services.
- A private room, when the hospital has semi-private rooms (CareFirst will base payment on the average semi-private room rate).
- Inpatient Private Duty Nursing.
- Outpatient Private Duty Nursing.
- Surgical removal of impacted teeth.

- Any hearing care provided after the date a covered person's coverage terminates.

General Anesthesia for Dental Care

Benefits for general anesthesia and associated hospital or ambulatory facility charges in conjunction with dental care will be provided to a covered person under the following circumstances:

- If the covered person is:
    - Seven years of age or younger, or developmentally disabled;
    - An individual for whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual, or other medically compromising condition of the covered person; and
    - An individual for whom a superior result can be expected from dental care provided under general anesthesia.
- Or, if the covered person is:
    - Seventeen years of age or younger;
    - An extremely uncooperative, fearful, or uncommunicative individual;
    - An individual with dental needs of such magnitude that treatment should not be delayed or deferred; and
    - An individual for whom lack of treatment can be expected to result in severe oral pain, significant infection, loss of multiple teeth, or other serious oral or dental morbidity.
- Or, if the covered person has a medical condition that requires admission to a hospital or ambulatory surgical facility and general anesthesia for dental care.
- Benefits for general anesthesia and associated hospital or ambulatory facility charges are restricted to dental care that is provided by:
    - A fully accredited specialist in pediatric dentistry;

- A fully accredited specialist in oral and maxillofacial surgery; and
- A dentist who has been granted hospital privileges.

- This provision does not provide benefits or general anesthesia and associated hospital or ambulatory facility charges for dental care rendered for temporomandibular joint disorders.

The Plan will not provide a benefit for dental care for which general anesthesia is provided.

Ambulance Services (Emergency and Non-Emergency)

The Plan covers Medically Necessary, emergency and non-emergency air transportation, surface, and ground ambulance services, as determined by CareFirst.

The Plan covers in-network and out-of-network ambulance services providers differently. If you receive Covered Services from an in-network ambulance services provider, the cost to you may be lower than if you receive services from an out-of-network ambulance services provider.

Except for Medically Necessary ambulance services, the Plan will not provide a benefit for travel whether or not recommended by a Provider. Additional limited travel benefits related to an organ transplant may be covered to the extent described under the Organ/Tissue Transplants benefit.

Organ/Tissue Transplants

Recipient/Donor Services

Under the Plan, when a covered person is the recipient of a transplant, benefits are available for both the covered person recipient and the non-covered person donor. Donor benefits are available only to the extent that benefits are not available from another source, such as other group health plan coverage or another health insurance plan.

When a covered person is the donor of a transplant, no benefits are available under the Plan.

Covered Services

The Plan covers the following organ/tissue transplant services:

- 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.

- Donor Services limited to the extent stated above.

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

- Immunosuppressant maintenance drugs when prescribed for a covered transplant.

- Organ transplant procurement benefits for the recipient, as follows:

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

    - 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.

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

- Cost of hotel lodging and air transportation for the recipient-covered person and a companion (or the recipient-covered person and two companions, if the recipient-covered person is under the age of eighteen years) to and from the site of the transplant, if approved by CareFirst. This benefit is available only when the covered transplant is not performed in the Service Area.

Additional Requirements

The organ transplant hospital must:

- Have fair and practical rules for choosing recipients and a written contract with someone that has the legal right to procure donor organs;

- Conform to all laws that apply to organ transplants; and

- Be approved by CareFirst.

At least thirty days before the start of a planned organ transplant, the recipient's physician must give CareFirst written notice including:

- Proof of Medical Necessity;
- Diagnosis;
- Type of surgery; and
- Prescribed treatment.

Donor Services consist of services covered under the Plan that are related to the transplant surgery, including evaluating and preparing the actual donor, regardless of whether the transplant is attempted or completed, and recovery services after the donor procedure, which are directly related to donating the organ or tissue.

Related Services means services or supplies for, or related to organ/tissue transplant procedures, including, but not limited to: diagnostic services, inpatient/outpatient Provider services, Prescription Drugs (to the extent covered by the Plan), surgical services, Occupational Therapy, Physical Therapy, and Speech Therapy.

The Plan will not provide a benefit for:

- Any and all services for or related to any organ transplants except those deemed Medically Necessary and non-Experimental/Investigational by CareFirst.
- Any organ transplant or procurement done outside the continental United States.
- An organ transplant relating to a condition arising from and in the course of employment.
- Organ and tissue transplant Covered Services if there are research funds to pay for the Covered Services.
- Expenses incurred for the location of a suitable donor (*e.g.*, search of a population or mass screening).

Prescription Drugs (Non-Pharmacy)

The Plan provides a benefit for prescription drugs dispensed in the office/place of service of a Provider. Benefits are available for injectable prescription drug contraceptives and

contraceptive devices approved by the U.S. Food and Drug Administration for use as a contraceptive, prescribed by a Provider, and dispensed in the office/place of service of a Provider. Benefits are also available for injectable prescription drugs that require administration by a Provider. Benefits are not available for outpatient Prescription Drugs or routine immunizations and boosters (except as otherwise provided in the description of Covered Services).

Note: Pharmacy-dispensed prescription drugs are addressed in the section below entitled "Prescription Drug Benefits."

Controlled Clinical Trial Patient Cost Coverage

Benefits will be provided to a covered person in a Controlled Clinical Trial if the covered person's participation in the Controlled Clinical Trial is the result of:

- Treatment provided for a life-threatening condition; or
- Prevention, early detection, and treatment studies on cancer.

Coverage will be provided only if:

- The treatment is being provided or the studies are being conducted in a Phase I, Phase II, Phase III, or Phase IV Controlled Clinical Trial for cancer; or
- The treatment is being provided in a Phase I, Phase II, Phase III, or Phase IV Controlled Clinical Trial for any other life-threatening condition;
- The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise;
- There is no clearly superior, non-Experimental/Investigational treatment alternative; and
- The available clinical or pre-clinical data provide a reasonable expectation that the treatment will be at least as effective as the non-Experimental/Investigational alternative.
- Prior authorization has been obtained from CareFirst.

Coverage is provided for the Patient Cost incurred for drugs and devices that have been approved for sale by the U.S. Food and Drug Administration whether or not it has

approved the drug or device for use in treating the covered person's particular condition, to the extent that the drugs or devices are not paid for by the manufacturer, distributor, or provider of that drug or device.

Controlled Clinical Trial means a treatment that is:

1. Approved by an institutional review board;

2. Conducted for the primary purpose of determining whether or not a particular treatment is safe and efficacious; and

3. Is approved by:

   a. The National Institutes of Health (NIH) or a Cooperative Group.

   b. The Centers for Disease Control and Prevention.

   c. The Agency for Health Care Research and Quality.

   d. The Centers for Medicare & Medicaid Services.

   e. Cooperative group or center of any of the entities described in clauses (3)(a) through (3)(d) above or the Department of Defense or the Department of Veterans Affairs.

   f. A qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants.

   g. The Department of Veterans Affairs, the Department of Defense or the Department of Energy, if the study or investigation has been reviewed and approved through a system of peer review that has been determined:

      i. To be comparable to the system of peer review of studies and investigations used by the NIH, and

      ii. Assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

   h. The U.S. Food and Drug Administration in the form of an investigational new drug application.

i. An institutional review board of an institution in a state that has a Multiple Project Assurance Contract approved by the Office of Protection from Research Risks of the NIH.

Cooperative Group means a formal network of facilities that collaborate on research projects and have an established NIH-approved peer review program operating within the group. Cooperative Group includes the National Cancer Institute Clinical Cooperative Group; the National Cancer Institute Community Clinical Oncology Program; the AIDS Clinical Trials Group; and the Community Programs For Clinical Research in AIDS.

Multiple Project Assurance Contract means a contract between an institution and the federal Department of Health and Human Services that defines the relationship of the institution to the United States Department of Health and Human Services and sets out the responsibilities of the institution and the procedures that will be used by the institution to protect human subjects.

NIH means the National Institutes of Health.

Patient Cost means the cost of a Medically Necessary health care service that is incurred as a result of the treatment being provided to the covered person for purposes of the clinical trial. Patient Cost does not include the cost of an Investigational drug or device, the cost of non-health care services that a covered person may be required to receive as a result of the treatment being provided for purposes of the clinical trial, costs associated with managing the research associated with the clinical trial, or costs that would not be covered under this Plan for non-Investigational treatments.

Mastectomy-Related Services

The Plan covers the following mastectomy-related services:

- Coverage for reconstructive breast surgery, including coverage for all stages of reconstructive breast surgery performed on a non-diseased breast to establish symmetry with the diseased breast when reconstructive breast surgery is performed on the diseased breast including augmentation mammoplasty, reduction mammoplasty, and mastopexy;

- Breast prostheses prescribed by a physician for a covered person who has undergone a mastectomy and has not had breast reconstruction;

- Physical complications from all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the covered person; and

- Inpatient hospital services for a minimum of forty-eight (48) hours following a mastectomy as a result of breast cancer. A covered person may request a shorter length of stay if the covered person decides, in consultation with the attending physician, that less time is needed for recovery.

- Home Health Care services, as stated in the *Home Health Care* services section of the description of Covered Services.

Diabetes-Related Services

Coverage will be provided for all Medically Necessary and medically appropriate equipment when deemed by the treating physician or other appropriately licensed Provider to be necessary for the treatment of diabetes (Types I and II), elevated or impaired blood glucose levels induced by pregnancy or consistent with the American Diabetes Association's standard, elevated or impaired blood glucose levels induced by prediabetes.

Coverage will be provided for all Medically Necessary and medically appropriate diabetic supplies when deemed by the treating physician or other appropriately licensed Provider to be necessary for the treatment of diabetes (Types I and II), elevated or impaired blood glucose levels induced by pregnancy or consistent with the American Diabetes Association's standard, elevated or impaired blood glucose levels induced by prediabetes. Diabetes supplies include coverage for insulin syringes and needles and testing strips for glucose monitoring equipment.

Coverage will be provided for all Medically Necessary and medically appropriate diabetes outpatient self-management training and educational services, including medical nutrition therapy, when deemed by the treating physician or other appropriately licensed Provider to be necessary for the treatment of diabetes (Types I and II), or elevated blood glucose levels induced by pregnancy.

If deemed necessary, diabetes outpatient self-management training and educational services, including medical nutrition therapy, shall be provided through an in-person program supervised by an appropriately licensed, registered, or certified Provider whose scope of practice includes diabetes education or management.

Professional Nutritional Counseling/Medical Nutrition Therapy

Benefits are available for Professional Nutritional Counseling, to include Medical Nutrition Therapy services, when Medically Necessary as determined by CareFirst.

Professional Nutritional Counseling means individualized advice and guidance given to a covered person at nutritional risk due to nutritional history, current dietary intake, medication use or chronic illness, about options and methods for improving nutritional status. Professional Nutritional Counseling must be provided by a registered licensed dietitian or other eligible Provider, as determined by CareFirst.

Medical Nutrition Therapy, provided by a registered dietitian, involves the assessment of the covered person'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 such as cardiovascular disease, diabetes mellitus, hypertension, kidney disease, eating disorders, gastrointestinal disorders, seizure disorders (e.g., ketogenic diet), and other conditions based on the efficacy of diet and lifestyle on the treatment of these disease states. Registered dietitians, working in a coordinated, multidisciplinary team effort with the primary care physician, take into account a covered person's food intake, physical activity, course of any medical therapy including medications and other treatments, individual preferences, and other factors.

Surgical Treatment of Morbid Obesity
Benefits are available for the treatment of Morbid Obesity through gastric bypass surgery or methods recognized by the NIH as effective for the long-term reversal of Morbid Obesity.

Morbid Obesity means:

- A weight that is at least one hundred (100) pounds over or twice the ideal weight for frame, age, weight, height, and gender as specified in the 1983 Metropolitan Life Insurance Tables; or
- A BMI of at least thirty-five (35) kilograms per meter squared with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea or diabetes; or
- A body mass index (BMI) of forty (40) kilograms without such comorbidity.

Body Mass Index (BMI) means a practical marker used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

NIH means the National Institutes of Health.

Transgender Services

Benefits are available in accordance with recognized professional standard of medical

care for transgender individuals requiring treatment for gender dysphoria, as enumerated in the most recent edition of the World Professional Association for Transgender Health Standards of Care ("WPATH Standards").

Benefits include gender assignment/reassignment counseling and surgery, and hormone replacement therapy.

Benefits are not provided for Cosmetic surgery or for reversal of gender reassignment surgery.

Rehabilitative Services

The Plan covers the following rehabilitative services:

- **Inpatient Rehabilitative Services**. Benefits are available for inpatient Rehabilitative Services.

- **Outpatient Rehabilitative Services**. Benefits are available for the following outpatient Rehabilitative Services:

  - Occupational Therapy

  - Physical Therapy; and

  - Speech Therapy.

- **Cardiac Rehabilitation**. Benefits for Cardiac Rehabilitation are provided to a covered person who has been diagnosed with significant cardiac disease, as defined by CareFirst, or, who, immediately preceding referral for Cardiac Rehabilitation, suffered a myocardial infarction or has undergone invasive cardiac treatment, as defined by CareFirst. All services must be Medically Necessary as determined by CareFirst in order to be covered. Services must be provided at a place of service equipped and approved to provide Cardiac Rehabilitation.

  Benefits will not be provided for maintenance programs.

  "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 an eligible covered person.

- **Pulmonary Rehabilitation**. Benefits are provided to covered persons who have been diagnosed with significant pulmonary disease, as defined by CareFirst, or, who have undergone certain surgical procedures of the lung, as defined by CareFirst. Coverage is provided for all Medically Necessary services, as determined by CareFirst. Services must be provided at a place of service equipped and approved to provide Pulmonary Rehabilitation.

  Benefits will not be provided for maintenance programs.

- **Visual Therapy**. Benefits are available for outpatient visual therapy.

The Plan will not provide a benefit for services delivered through early intervention and school services. The Plan will not provide a benefit for Habilitative Services, except as stated in the Autism Spectrum Disorder subsection of this Description of Covered Medical Services. **Habilitative Services** means the process of educating or training persons with a disadvantage or disability caused by a medical condition or injury to improve their ability to function in society, where such ability did not exist, or was severely limited, prior to the habilitative education or training.

Emergency Services and Urgent Care

The following emergency services and urgent care services are covered:

- With respect to an Emergency Medical Condition, Emergency Services evaluation, examination, and treatment to stabilize the covered person.

- Urgent care services.

- Follow-up care after emergency surgery.

- Ambulance Services, as stated in the description of Covered Services.

Follow-up care after emergency surgery is limited to Covered Services provided by the Provider who performed the surgical procedure. The covered person will be responsible for the same copayment for each follow-up visit as would be required for a visit to an in-network Provider for specialty care.

Except for covered ambulance services, the Plan will not provide a benefit for travel, including travel required to return to the Service Area, whether or not recommended by a Provider. Additional limited travel benefits related to an organ transplant may be covered under the Organ/Tissue Transplants benefit.

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

- A medical screening examination (as required by Social Security Act section 1867) that is 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

- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital (as required by Social Security Act section 1867), to stabilize the covered person (as defined in Social Security Act section 1867(e)(3)).

Emergency Medical Condition means a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention 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.

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 free-standing facility that is not a physician's office and which provides Urgent Care.

HOME HEALTH CARE SERVICES

The Plan covers the following home health care services:

- Home Health Care, as defined below.

- Home visits following childbirth, including any services required by the attending Provider:

    - For a covered person and dependent child(ren) who remain in the hospital for at least 48 hours after an uncomplicated vaginal delivery, or ninety-six

(96) hours after an uncomplicated cesarean section, one home visit following childbirth, if prescribed by the attending Provider;

- For a covered person who, in consultation with her attending Provider, requests a shorter hospital stay (less than forty-eight (48) hours following an uncomplicated vaginal delivery or ninety-six (96) hours following an uncomplicated cesarean section):
    - One home visit following childbirth scheduled to occur within twenty-four (24) hours after discharge;
    - An additional home visit following childbirth if prescribed by the attending Provider.
- An attending Provider may be an obstetrician, pediatrician, other physician, certified nurse-midwife, or pediatric nurse Provider, attending the covered person or newborn dependent child(ren).
- Home visits following childbirth must be rendered, as follows:
    - In accordance with generally accepted standards of nursing practice for home-care of a mother and newborn children;
    - By a registered nurse with at least one year of experience in maternal and child health nursing or in community health nursing with an emphasis on maternal and child health.
- Home visits following a mastectomy as a result of breast cancer, as follows:
    - For a covered person who receives less than forty-eight (48) hours of inpatient hospitalization following a mastectomy or who undergoes a mastectomy on an outpatient basis, benefits will be provided for:
        - One home visit scheduled to occur within twenty-four (24) hours after discharge from the hospital or outpatient health care facility; and
        - An additional home visit if prescribed by the covered person's attending physician.

  - For a covered person who remains in the hospital for at least forty-eight (48) hours following a mastectomy, coverage will be provided for a home visit if prescribed by the covered person's attending physician.

- Home visits following the surgical removal of a testicle:

  - For a covered person who receives less than forty-eight (48) hours of inpatient hospitalization following the surgical removal of a testicle, or who undergoes the surgical removal of a testicle on an outpatient basis:

    - One home visit following the surgical removal of a testicle scheduled to occur within twenty-four (24) hours after discharge; and

    - An additional home visit following the surgical removal of a testicle if prescribed by the attending physician.

The following limitations apply:

- The Home Health Care Visits must be a substitute for hospital care or for care in a Skilled Nursing Facility (*i.e.*, if Home Health Care Visits were not provided, the covered person would have to be admitted to a hospital or Skilled Nursing Facility).

- The covered person must be confined to "home" due to a medical condition. "Home" cannot be an institution, convalescent home or any facility which is primarily engaged in rendering medical or Rehabilitative Services to the sick, disabled or injured persons.

- Services of a home health aide, medical social worker or registered dietician must be performed under the supervision of a licensed professional nurse (RN or LPN).

- The covered person must require and continue to require Skilled Nursing Care or Rehabilitative Services in order to qualify for home health aide services or other types of Home Health Care.

Home Health Care means the continued care and treatment of a covered person by a Provider in the home if:

- The covered person is under the care of a Provider; and

- Institutionalization of the covered person would have been required, and deemed Medically Necessary by CareFirst, if Home Health Care was not provided.

The Plan will not provide a benefit for:

- Rental or purchase of renal dialysis equipment and supplies.
- “Meals-on-Wheels” type food plans.
- Domestic or housekeeping services.
- Care that, after training by skilled personnel, can be rendered by a non-Provider, such as one of the covered person’s family or a friend (*e.g.*, change dressing for a wound).

HOSPICE CARE SERVICES

Hospice care benefits are available for a terminally ill covered person (medical prognosis by a physician that the covered person’s life expectancy is six months or less) when the covered person is under the care of a Provider.

The Plan covers the following hospice care services and supplies:

- Inpatient and outpatient hospice facility services;
- Part-time nursing care by or supervised by a registered graduate nurse;
- Counseling;
- Medical Supplies, Durable Medical Equipment and Prescription Drugs required to maintain the comfort and manage the pain of the covered person;
- Medical care by the attending physician;
- Respite Care;
- Other Medically Necessary health care services at CareFirst’s discretion.

Additionally, hospice care benefits are available for a covered person’s family and/or Caregiver for periodic family counseling before the covered person’s death, and bereavement counseling.

Caregiver means a person who is not a Provider who lives with or is the primary caregiver of the covered person in the home. The Caregiver can be a relative by blood, marriage or adoption or a friend of the covered person, but cannot be a person who normally charges for giving services. However, at CareFirst's discretion, a Caregiver may be an employee of a hospice care hospital/agency.

Hospice Care Program means a coordinated, interdisciplinary program of hospice care services for meeting 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.

Respite Care means short-term care for a covered person that provides relief to the Caregiver.

The Plan will not provide a benefit for:

- Any services other than palliative treatment.
- Rental or purchase of renal dialysis equipment and supplies.
- Domestic or housekeeping services.
- "Meals on Wheels" or similar food arrangements.

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

Mental Health and Substance Use Disorder Services, Including Behavioral Health Treatment

The Plan provides a benefit for the following inpatient/outpatient mental health and substance use disorder services, including behavioral health treatment:

- **Inpatient Services**. Benefits are provided when the covered person is admitted as an inpatient to a hospital or other health care facility for the treatment of mental illness, emotional or behavioral disorders, or substance use disorders, as follows:
    - Hospital or inpatient facility benefits, as described in the *Physician and Provider Services* section of the description of Covered Services.

- **Residential Crisis Services**. Benefits are provided for Medically Necessary Residential Crisis Services.

- **Outpatient services**. Benefits are available for outpatient treatment of mental illness, emotional or behavioral disorders, or substance use disorder, including:

    - Outpatient services for the diagnosis, care, and treatment of mental health and substance use disorders, including behavioral health treatment;

    - Partial Hospitalization services;

    - Psychological and neuropsychological testing for diagnostic purposes;

    - Methadone maintenance treatment; and

    - Visits with a Provider for prescription, use, and review of medication that include no more than minimal psychotherapy.

Partial Hospitalization means the provision of medically directed intensive or intermediate short-term treatment in a licensed or certified facility or program for treatment of mental illnesses, emotional or behavioral disorders, or substance use disorders.

Residential Crisis Services means intensive mental health and support services that are:

- Provided to a child or an adult covered person with a mental illness who is experiencing or is at risk of a psychiatric crisis that would impair the ability of the covered person to function in the community; and

- Designed to prevent a psychiatric inpatient admission, provide an alternative to psychiatric inpatient admission, shorten the length of inpatient stay, or reduce the pressure on general hospital emergency departments; and

- Provided by entities that are licensed by the applicable licensing laws of any state or the District of Columbia to provide Residential Crisis Services; or

- Located in subacute beds in an inpatient psychiatric facility for an adult covered person.

The Plan does not provide a benefit for:

- Marital counseling.
- Wilderness programs.
- Boarding schools.

Autism Spectrum Disorders

Covered Services for a covered person, to the extent CareFirst determines they are Medically Necessary:

- The diagnosis of Autism Spectrum Disorders; and
- Evidence-based, Medically Necessary Treatment of Autism Spectrum Disorders, as determined by CareFirst.

Autism Spectrum Disorders means any of the pervasive developmental disorders, as described in the current version of the diagnostic and statistical manual of mental disorders.

Diagnosis of Autism Spectrum Disorders means Medically Necessary assessments, evaluations, or tests to diagnose whether a covered person has an Autism Spectrum Disorder.

Treatment of Autism Spectrum Disorders means Habilitative or Rehabilitative Care prescribed to a covered person diagnosed with an Autism Spectrum Disorder as part of a plan of treatment that includes therapeutic goals and outcome measures.

Habilitative or Rehabilitative Care means, for purposes of Autism Spectrum Disorder coverage only, professional, counseling, and guidance services and treatment programs, including behavioral health treatments such as Applied Behavior Analysis, and devices that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of a covered person.

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.

The Plan will not provide a benefit for:

- Services delivered through early intervention and school services.

- Treatment of Autism Spectrum Disorders that CareFirst determines is not Medically Necessary.

MEDICAL DEVICES AND SUPPLIES

The Plan covers the following medical devices and supplies:

- **Durable Medical Equipment**. Rental, or, (at CareFirst's option), purchase and replacements or repairs of Medically Necessary Durable Medical Equipment prescribed by a Provider for therapeutic use for a covered person's medical condition.

  Durable Medical Equipment or supplies associated or used in conjunction with Medically Necessary medical foods and nutritional substances.

  CareFirst's payment for rental will not exceed the total cost of purchase. CareFirst's
  payment is limited to the least expensive Medically Necessary Durable Medical Equipment, adequate to meet the covered person's medical needs. CareFirst's payment for Durable Medical Equipment includes related charges for handling, delivery, mailing and shipping, and taxes.

- **Hair Prosthesis**. Benefits are available for a hair prosthesis when prescribed by a treating oncologist and the hair loss is a result of chemotherapy or radiation treatment for cancer.

- **Hearing Aids**. Benefits are available for Hearing Aids if:

  - The prescription is based upon the most recent audiometric exam and Hearing Aid Evaluation Test; and

  - A physician or audiologist certifies that the Hearing Aid provided by the hearing aid specialist conforms to the prescription.

  CareFirst's payment for Hearing Aids is limited to the Hearing Aid Allowed Benefit. Due to the wide variation in Hearing Aid device technology, the Hearing Aid

Allowed Benefit amount does not always cover the full cost of the hearing aid device(s) the covered person selects. If the covered person selects a Hearing Aid device(s) where the full cost is not covered by the Hearing Aid Allowed Benefit, the covered person will be fully responsible for paying the remaining balance for the Hearing Aid device(s) up to the provider's charge.

Benefits are also available for non-routine services related to the dispensing of a covered Hearing Aid, such as assessment, fitting, orientation, conformity and evaluation, within six months of audiometric testing;

- **Medical Foods and Nutritional Substances**. Medically Necessary medical foods and nutritional therapy for the treatment of disorders when ordered and supervised by a Provider qualified to provide the diagnosis and treatment in the field of the disorder/disease, as determined by CareFirst.

- **Medical Supplies**. Benefits are available for Medical Supplies as such supplies are defined below.

- **Orthotic Devices**. Benefits include:

  - Medically Necessary Orthotic Devices;

  - Supplies and accessories necessary for effective functioning of a covered Orthotic Device;

  - Repairs or adjustments to Medically Necessary Orthotic Devices that are required due to bone growth or change in medical condition, reasonable weight loss or reasonable weight gain, and normal wear and tear during normal usage of the device;

  - Replacement of covered Orthotic Devices when repairs or adjustments fail and/or are not possible; and

  - Repair of covered Orthotic Devices.

  - Orthotic Device benefits are limited as follows:

    - Benefits for the repair, maintenance or replacement of a covered Orthotic Device require authorization or approval by CareFirst.

    - Coverage of maintenance costs is limited to routine servicing such as testing, cleaning, regulating and checking of equipment.

- Coverage of repair costs is limited to adjustment required by normal wear or by a change in the covered person's condition and repairs necessary to make the Orthotic Device serviceable. Repair will not be authorized if the repair costs exceed the market value of the Orthotic Device.

- Replacement coverage is limited to once every two benefit years due to irreparable damage and/or normal wear or a significant change in medical condition. Replacement costs necessitated as a result of malicious damage, culpable neglect, or wrongful disposition of the Orthotic Device on the part of the covered person or of a family member are not covered.

- **Prosthetic Devices**. Benefits include:

  - Medically Necessary Prosthetic Devices;

  - Supplies and accessories necessary for effective functioning of a covered Prosthetic Device;

  - Repairs or adjustments to Medically Necessary Prosthetic Devices that are required due to bone growth or change in medical condition, reasonable weight loss or reasonable weight gain, and normal wear and tear during normal usage of the device;

  - Replacement of covered Prosthetic Devices when repairs or adjustments fail and/or are not possible; and

  - Repair of covered Prosthetic Devices.

  - Prosthetic Device benefits are limited, as follows:

    - Benefits for the repair, maintenance or replacement of a covered Prosthetic Device require authorization or approval by CareFirst.

    - Coverage of maintenance costs is limited to routine servicing such as testing, cleaning, regulating and checking of equipment.

    - Coverage of repair costs is limited to adjustment required by normal wear or by a change in the covered person's condition and repairs necessary to make the Prosthetic Device serviceable. Repair will not

be authorized if the repair costs exceed the market value of the Prosthetic Device.

- Replacement coverage is limited to once every two benefit years due to irreparable damage and/or normal wear or a significant change in medical condition. Replacement costs necessitated as a result of malicious damage, culpable neglect, or wrongful disposition of the Prosthetic Device on the part of the covered person or of a family member are not covered.

Durable Medical Equipment means equipment which:

- Is primarily and customarily used to serve a medical purpose;
- Is not useful to a person in the absence of illness or injury;
- Is ordered or prescribed by a physician or other qualified practitioner;
- Is consistent with the diagnosis;
- Is appropriate for use in the home;
- Is reusable; and
- Can withstand repeated use.

Hearing Aid Allowed Benefit means the dollar amount CareFirst allows for the particular hearing device in effect on the date that the service is rendered.

Hearing Aids means a device that is of a design and circuitry to optimize audibility and listening skills in the environment commonly experienced by covered persons and is non-disposable.

Medical Device means Durable Medical Equipment, Medical Supplies, Orthotic Devices and Prosthetic Devices.

Medical Supplies means items that:

- Are primarily and customarily used to serve a medical purpose;
- Are not useful to a person in the absence of illness or injury;

- Are ordered or prescribed by a physician or other qualified practitioner;
- Are consistent with the diagnosis;
- Are appropriate for use in the home;
- Cannot withstand repeated use; and
- Are usually disposable in nature.

Orthotic Device means orthoses and braces which:

- Are primarily and customarily used to serve a therapeutic medical purpose;
- Are prescribed by a Provider;
- Are corrective appliances that are applied externally to the body, to limit or encourage its activity, to aid in correcting or preventing deformity, or to provide mechanical support;
- May be purely passive support or may make use of spring devices;
- Include devices necessary for post-operative healing.

Prosthetic Device means a device which:

- Is primarily intended to replace all or part of an organ or body part that has been lost due to disease or injury; or
- Is primarily intended to replace all or part of an organ or body part that was absent from birth; or
- Is intended to anatomically replace all or part of a bodily function which is permanently inoperative or malfunctioning; and
- Is prescribed by a Provider; and
- Is removable and attached externally to the body.

The Plan will not provide a benefit for:

- Cranial molding orthoses for positional/deformational/non-synostotic plagiocephaly or brachycephaly.
- Durable Medical Equipment, except as stated in the description of Covered Services.
- Durable Medical Equipment or supplies associated or used in conjunction with non-covered items or services.
- Medical Supplies, except as stated in the description of Covered Services.
- Orthotic Devices, except as stated in the description of Covered Services.
- Prosthetic Devices, except as stated in the description of Covered Services.
- Food and formula consumed as sole source or supplemental nutrition, except as stated in the description of Covered Services.
- Hearing Aids, except as stated in the description of Covered Services.

VISION CARE SERVICES: ROUTINE VISION EXAM

CareFirst has contracted with Davis Vision, Inc., a national provider of Vision Care services, to administer Vision Care benefits. Davis Vision, Inc. is an independent company and administers Vision Care services on behalf of CareFirst.

Davis Vision, Inc. has special agreements with optometrists and ophthalmologists to provide Vision Care benefits to covered persons. These optometrists and ophthalmologists are Contracting Providers for which in-network benefits are provided. If a covered person chooses to obtain Vision Care from a Contracting Provider, the cost to the covered person is lower than if the covered person chooses a Non-Contracting Provider for which out-of-network benefits are provided.

Hereafter, for purposes of Vision Care, references to CareFirst shall also include Davis Vision, Inc.

The Plan covers one vision examination per Benefit Period, which may include, but is not limited to:

- Case history;

- External examination of the eye and adnexa;
- Ophthalmoscopic examination;
- Determination of refractive status;
- Binocular balancing test;
- Tonometry test for glaucoma;
- Gross visual field testing;
- Color vision testing;
- Summary finding; and
- Recommendation, including prescription of corrective lenses.

Allowed Benefit, for purposes of Vision Care, means:

- For a Contracting Provider, the Allowed Benefit for a Covered Service is the lesser of:
  - The actual charge; or
  - The amount allowed for the service in effect on the date that the service is rendered.

  The benefit is payable to the Contracting Provider and is accepted as payment in full, except for any applicable covered person payment amounts, as stated in the Schedule of Benefits.

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

  The benefit is payable to the Subscriber or to the Non-Contracting Provider, at the discretion of CareFirst. If CareFirst pays the Subscriber, it is the covered person's responsibility to pay the Non-Contracting Provider. Additionally, the covered person is responsible for any applicable covered person payment amounts, as

stated in the Schedule of Benefits, and for the difference between the Allowed Benefit and the Non-Contracting Provider's actual charge.

Contracting Provider means any optometrist or ophthalmologist licensed as such by the duly constituted authority in the jurisdiction in which Vision Care is rendered when acting within the scope of such license; and that has contracted with Davis Vision, Inc. to provide Vision Care services on behalf of CareFirst. The covered person should contact Davis Vision, Inc. for the current list of Contracting Providers.

Non-Contracting Provider means any optometrist or ophthalmologist licensed as such by the duly constituted authority in the jurisdiction in which Vision Care is rendered when acting within the scope of such license; and that does not have an agreement with Davis Vision, Inc. for the rendering of Vision Care services on behalf of CareFirst. A Non-Contracting Provider under this section may or may not have contracted with CareFirst.

Vision Care means those services for which benefits are provided under this "Vision Care" section.

The Plan will not provide a benefit for:

- Diagnostic services except as described in this "Vision Care" section.
- Prescription Drugs except as may be necessary for a vision exam.
- Orthoptics, vision training, and low vision aids.
- Vision Care services for cosmetic use.
- Frames, lenses, sunglasses, or contact lenses.

CARE SUPPORT PROGRAMS

The Plan also makes available Care Support, Substance Use Disorder, Health Promotion and Wellness, and Disease Management Services to covered persons (other than those for whom Medicare or Medicaid is the primary coverage).

Care Support Programs

- Benefits are available to qualified individuals with certain conditions or complex health care needs, as determined by CareFirst, requiring care support and coordination of health services. These benefits are to manage the care of certain

complex chronic or high-risk acute diseases when provided by Designated Providers or through CareFirst and are covered at no cost to the Qualified Individual. Covered Services provided under Care Support Programs can include but are not limited to telemedicine services; case management services; expert consultation services; medication review services; medical equipment and monitoring services; and home health care services.

- Covered Services received as part of a Care Support Program are subject to applicable contract limits, Deductibles, Copayments, and/or Coinsurance as stated in the Schedule of Benefits.

- Coverage will not be provided for services rendered by non-Designated Providers.

Substance Use Disorder Program

- Program benefits will be provided for outpatient treatment of Substance Use Disorder in accordance with the Substance Use Disorder Program if: (1) the covered person qualifies for the Substance Use Disorder Program, as determined by CareFirst; (2) the covered person receives treatment from a Designated Provider, as determined by CareFirst; and (3) treatment is rendered though an intensive outpatient program (IOP) or an outpatient program at a Designated Provider as determined by CareFirst.
- no Copayment and/or Coinsurance associated with services provided under this program. The Deductible, if any, does not apply to Covered Service provided under this provision.

Health Promotion and Wellness Covered Services

- Health assessments are available for all adult covered persons.

- Benefits may also be available for biometric screenings.

- Lifestyle coaching sessions are available as follows: (1) an initial discussion with a lifestyle coach to establish defined goal(s) for wellness coaching, and to determine the frequency of future coaching sessions; and (2) after the initial discussion, sessions to track, support, and advance the covered person's wellness/lifestyle goal(s).

- Other wellness program benefits are available, which may include tobacco-cessation, well-being challenges, and financial well-being improvement programs.

- Weight loss services are available to covered persons with a BMI score greater than thirty (30). A coach assists with the development of healthy eating and physical activity habits and with addressing the emotional, social, and environmental aspects shown to be important for sustained weight loss. The covered person receives one-on-one telephonic interventions with the coach and online educational resources, robust food, exercise trackers, recipes, peer-to-peer communication, and group community features for complete social support and accountability.

Disease Management Covered Services

- Disease management services, which may include a disease management program to help the covered person understand his/her disease and health status and physician treatment plans, individual and family education regarding the disease, treatment compliance and self-care techniques, and help to organize care for the disease, including arranging for needed services and supplies.

- Disease management coaching sessions consist of the following: (1) an initial discussion with a coach to establish defined goal(s) for disease management coaching, and to determine the frequency of future coaching sessions in order to best meet the established goal(s) and manage the disease; and (2) after the initial discussion, sessions to track, support, and advance the covered person's disease management goal(s).

SUMMARY PLAN DESCRIPTION
As of January 1, 2020

EXCLUSIONS AND LIMITATIONS

This section lists services or conditions for which benefits are not available under the Plan.

The Plan will not provide a benefit 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.

- Services that are not described as Covered Services or that do not meet all other conditions and criteria for coverage, as determined by CareFirst. Provision of services, even if Medically Necessary, by a preferred Provider does not, by itself, entitle a covered person to benefits if the services are excluded or do not otherwise meet the conditions and criteria for coverage.

- Services that are Experimental/Investigational or not in accordance with accepted medical or psychiatric practices and standards in effect at the time the service in question is rendered, as determined by CareFirst.

- Services or supplies received at no charge to a covered person in any federal hospital, or through any federal, state or local governmental agency or department, or not the legal obligation of the covered person, or where the charge is made only to insured persons.

  This exclusion does not apply to:

  - Medicaid; or

  - Care received in a veteran’s hospital unless the care is rendered for a condition that is a result of a covered person’s military service.

- 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.

- Routine dental care such as services, supplies, or charges directly related to the care, restoration, removal or replacement of teeth, the treatment of disease of the teeth, gums or structures directly supporting or attached to the teeth.

- Cosmetic services (except for mastectomy-related services and services for cleft lip or cleft palate or both).

- Treatment rendered by a Provider who is the covered person's parent, child, grandparent, grandchild, sister, brother, great grandparent, great grandchild, aunt, uncle, niece, or nephew or resides in the covered person's home.

- All non-prescription drugs, medications, and biologicals, routinely obtained and self-administered by the covered person, unless otherwise a Covered Service.

- All Over-the-Counter items and supplies, routinely obtained and self-administered by the covered person including, but not limited to: non-prescription eye wear; cosmetics or health and beauty aids; food and nutritional items; support devices; non-medical items; first aid and miscellaneous medical supplies (whether disposable or durable); personal hygiene supplies; incontinence supplies; and Over-the-Counter solutions, except for Over-the-Counter medication or supply dispensed under a written prescription by a Provider that is identified in the current recommendations of the United States Preventive Services Task Force that have in effect a rating of “A” or “B”.

- Lifestyle improvements, including, but not limited to health education classes and self-help programs, except as stated in the description of Covered Services.

- 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.

- Treatment for weight reduction and obesity, except for the surgical treatment of Morbid Obesity, as described in the description of Covered Services, and Covered Services provided under the Disease Management Program. This exclusion does not apply to the treatment of childhood obesity as required by the Patient Protection and Affordable Care Act.

- Routine eyeglasses or contact lenses.

- Medical or surgical treatment of myopia or hyperopia. Coverage is not provided for radial keratotomy and any other forms of refractive keratoplasty, or any complications.

- Services furnished as a result of a referral prohibited by law.

- Any recreational activity intended as a rehabilitative service. This includes, but is not limited to: sports, games, horseback riding, and athletic training, even though such services may have therapeutic value or be provided by a Provider.

- Non-medical Provider services, including, but not limited to:

    - Telephone consultations, charges for failure to keep a scheduled visit, completion of forms, copying charges or other administrative services provided by the Provider or his/her staff.

    - Administrative fees charges by a Provider to a covered person to retain the Provider’s medical practices services, e.g., “concierge fees” or boutique medical practice membership fees. Benefits under this Plan are limited to Covered Services rendered to a covered person by a Provider.

- Educational therapies intended to improve academic performance.

- Vocational rehabilitation and employment counseling.

- Services related to an excluded service (even if those services or supplies would otherwise be Covered Services) except General Anesthesia for Dental Care.

- Separate billings for health care services or supplies furnished by an employee of a Provider which are normally included in the Provider’s charges and billed for by them.

- Services that are non-medical in nature, including, but not limited to personal hygiene, cosmetic and Convenience Items, including, but not limited to, air conditioners, humidifiers, exercise equipment, elevators or ramps.

- Personal comfort items, even when used by a covered person in an inpatient hospital setting, such as telephones, televisions, guest trays, or laundry charges.

- Custodial, personal, or domiciliary care that is provided to meet the activities of daily living; e.g., bathing, toileting, and eating (care which may be provided by persons without professional medical skills or training).

- Self-care or self-help training designed to enable a covered person to cope with a health problem or to modify behavior for improvement of general health unless otherwise stated.

- Services intended to increase the intelligence quotient (IQ) of covered persons with an intellectual disability or to provide cure for primary developmental disabilities, if such services do not fall within generally accepted standards of medical care.

- Services for the purpose of controlling or overcoming delinquent, criminal, or socially unacceptable behavior unless deemed Medically Necessary by CareFirst.

- Milieu care or in-vivo therapy: care given to change or control the environment, supervision to overcome or control socially unacceptable behavior, or supervised exposure of a phobic individual to the situation or environment to which an abnormal aversion is related.

- Services related to human reproduction other than specifically described in this Summary Plan Description including, but not limited to maternity services for surrogate motherhood or surrogate uterine insemination, unless the surrogate mother is a covered person.

- Blood products and whole blood when donated or replaced.

- Oral surgery, dentistry or dental processes unless otherwise stated, including removal or replacement of teeth, crowns, bridges, implants, orthodontics (except for orthodontic Covered Services for cleft lip or cleft palate), the operation or treatment for the fitting or wearing of dentures, periodontal therapy, direct or indirect restorations (fillings) root canal therapy, treatment of dental cysts and abscesses.

- Premarital exams.

- Services performed or prescribed by or under the direction of a person who is not a Provider.

- Services performed or prescribed by or under the direction of a person who is acting beyond his/her scope of practice.

- Services provided through a dental or medical department of an employer; a mutual benefit association, a labor union, a trust, or a similar entity.

- Services rendered or available under any Workers' Compensation or occupational disease, or employer's liability law, or any other similar law, even if a covered person fails to claim benefits. Exclusions to these laws exist for partnerships, sole proprietorships and officers of closed corporations. If a covered person is exempt from the above laws, the benefits of this Plan will be provided for Covered Services.

- Services provided or available through an agent of a school system in response to the requirements of the Individuals With Disabilities Education Act and Amendments, or any similar state or federal legislation mandating direct services to disabled students within the educational system, even when such services are of the nature that they are Covered Services when provided outside the educational domain.

- Any illness or injury caused by war (a conflict between nation states), declared or undeclared, including armed aggression.

- Exams and related services, and completion of forms, required solely for: employment, pre-employment screening, insurance, foreign travel, travel requirements, school, camp admissions/scouting programs, participation in sports activities (sports physicals), pre-adoption, adoption, pre-foster parenting, foster parenting, admission to old age home, driving license including commercial driving license, handicapped tag documentation, immigration and naturalization, marriage, prison, disability examination, FMLA verification, Workers' Compensation, attorney forms, or attendance for issue of medical certificates.

- Immunizations solely for foreign travel.

- Charges used to satisfy a covered person's dental care, prescription drug, or vision care benefits deductible, if applicable, or balances from any such programs.

- Financial and/or legal services.

- Dietary or nutritional counseling, except as stated in the description of Covered Services.

- Hearing care, except as stated in the description of Covered Services.

- Tinnitus maskers, purchase, examination, or fitting of Hearing Aids, except as stated in the description of Covered Services.

- Services solely required or sought on the basis of a court order or as a condition of parole or probation unless authorized or approved by CareFirst.

- 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.

SUMMARY PLAN DESCRIPTION
As of January 1, 2020

SCHEDULE OF MEDICAL BENEFITS

CareFirst pays only for Covered Services. Services that are not listed in the Description of Covered Services, or are listed in Exclusions, are not Covered Services.

Generally, services rendered in a hospital/facility result in claims both from the hospital/facility and from professional practitioners rendering care in the hospital/facility setting. In addition, certain Covered Services may result in claims for multiple services.

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Preventive and wellness services		
Primary purpose of the office visit is preventive and wellness services	**Limitations** Benefits for chlamydia screening are limited to one screening per Benefit Period. Benefits for adult routine physical exam are limited to one visit per Benefit Period. Benefits for routine gynecological (GYN) exam are limited to one visit per Benefit Period. Benefits for pap smear exam are limited to one visit per Benefit Period.	
Infant, child, and adolescent preventive and wellness services		
Office visit	No Deductible required 100% of Allowed Benefit	No Deductible required 100% of Allowed Benefit
Immunizations	No Deductible required 100% of Allowed Benefit	No Deductible required 100% of Allowed Benefit
Diagnostic services (including preventive screenings)	No Deductible required 100% of Allowed Benefit	No Deductible required 100% of Allowed Benefit
Adult preventive and wellness services		
Office visit	No Deductible required 100% of Allowed Benefit	No Deductible required 70% of Allowed Benefit
Immunizations	No Deductible required 100% of Allowed Benefit	No Deductible required 70% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Diagnostic services (including preventive screenings)	No Deductible required 100% of Allowed Benefit	No Deductible required 100% of Allowed Benefit
Primary purpose of the office visit is not the delivery of preventive and wellness services		
Office visit and, if not billed separately, preventive and wellness services	No Deductible required 100% of Allowed Benefit after $10 Copay	70% of Allowed Benefit
Subsequent treatment of a condition diagnosed during a preventive and wellness services office visit	Benefits are available to the same extent as benefits provided for other illnesses.	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Ambulance Services (Emergency and Non-Emergency)	**Limitations** Ambulance services are limited, as follows: • Licensed private ambulance firms or a municipal department or division authorized to provide such services pursuant to an existing law or ordinance.	
Ambulance Services	No Deductible required 100% of Allowed Benefit	No Deductible required 100% of Allowed Benefit*
*Nonparticipating providers will be priced at charge.		

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Autism Spectrum Disorders	**Limitations** Visit limits, including Rehabilitative Service visit limits, if any, do not apply.	
	Benefits are available to the same extent as in-network benefits provided for other illnesses.	Benefits are available to the same extent as out-of-network benefits provided for other illnesses.

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Controlled Clinical Trials Patient Costs	**Limitations** Hospital Pre-Certification and Review is required. An approved Plan of Treatment is required.	
	Benefits are available to the same extent as benefits provided for other illnesses.	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Diabetes-related services		
Diabetes equipment	No Deductible required 100% of Allowed Benefit	70% of Allowed Benefit
Diabetes supplies (except urine and blood testing strips for glucose monitoring equipment)	No Deductible required 100% of Allowed Benefit	No Deductible required 100% of Allowed Benefit
Urine and blood testing strips for glucose monitoring equipment	No Deductible required 100% of Allowed Benefit	No Deductible required 100% of Allowed Benefit
Diabetes self-management training	No Deductible required 100% of Allowed Benefit after $10 Copay	70% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Emergency Services and Urgent Care		
Emergency Services in a hospital emergency room/department		
Hospital emergency room/ department and ancillary services routinely available to the emergency room/department to evaluate an Emergency Medical Condition	80% of Allowed Benefit after $100 Copay Copay is waived if covered person is admitted.	Out-of-network benefits are available to the same extent as in-network benefits for Emergency Services in a hospital emergency room/department.

Covered Service	CareFirst Payment	
	In-Network	**Out-of-Network**
Outpatient professional practitioner(s) in hospital emergency room/department	80% of Allowed Benefit	Out-of-network benefits are available to the same extent as in-network benefits for Emergency Services provided by outpatient professional practitioner(s) in a hospital emergency room/department.
Covered person admitted as inpatient	Benefits are available to the same extent as other Inpatient Provider services.	
Evaluation, examination, and treatment that is not rendered in a hospital emergency room/department		
Office	No Deductible required 100% of Allowed Benefit after $10 Copay Copay applies to the office exam only.	70% of Allowed Benefit
Urgent Care center	No Deductible required 100% of Allowed Benefit after $10 Copay	70% of Allowed Benefit
Dental services related to accidental injury or trauma	**Limitations** Treatment must begin within six months of the accidental injury or trauma.	
	80% of Allowed Benefit	70% of Allowed Benefit
HIV Testing in a hospital emergency room	Benefits for HIV testing performed in a hospital emergency room are not subject to the Deductible.	

Covered Service	CareFirst Payment	
	In-Network	**Out-of-Network**
General anesthesia for dental care	**Limitations** An approved Plan of Treatment may be required.	
	Benefits are available to the same extent as benefits provided for other illnesses.	

Covered Service	CareFirst Payment	
	In-Network	**Out-of-Network**
Home Health Care	**Limitations** Hospital/home health agency: Ninety (90) days per "episode of care." A new episode of care begins if the covered person does not receive Home Health Care for the same or a different condition for sixty (60) consecutive days.	
Hospital/home health agency	80% of Allowed Benefit	70% of Allowed Benefit
Home visits following childbirth	80% of Allowed Benefit	70% of Allowed Benefit
Home visits following mastectomy	80% of Allowed Benefit	70% of Allowed Benefit
Home visits following the surgical removal of a testicle	80% of Allowed Benefit	70% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	**Out-of-Network**
Hospice care	**Limitations** An approved Plan of Treatment is required for hospice care; the Plan of Treatment must be accepted in writing by the covered person and/or family. Inpatient benefits are limited to a maximum one-hundred and eighty (180) days per lifetime. Outpatient benefits are limited to a maximum one-hundred and eighty (180) days per lifetime combined with inpatient benefits. Bereavement counseling is limited to the 90-day period following the covered person's death. Respite Care benefits are limited to a maximum of three, two-day periods per 180 days.	
Hospice facility services	80% of Allowed Benefit	70% of Allowed Benefit
Respite care	80% of Allowed Benefit	70% of Allowed Benefit

SUMMARY PLAN DESCRIPTION
As of January 1, 2020

Covered Service	CareFirst Payment	
	In-Network	**Out-of-Network**
Bereavement counseling	80% of Allowed Benefit	70% of Allowed Benefit
Family counseling	80% of Allowed Benefit	70% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	**Out-of-Network**
Infertility services	**Limitations** Benefits for artificial insemination (AI)/intrauterine insemination (IUI) and in vitro fertilization (IVF) are limited to a combined lifetime maximum benefit of $20,000.	
Artificial insemination (AI)/ intrauterine insemination (IUI)	**Limitations** An approved Plan of Treatment is required. Benefits for artificial insemination (AI)/intrauterine insemination (IUI) are limited to six attempts per live birth.	
Hospital/Outpatient facility	80% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	80% of Allowed Benefit	70% of Allowed Benefit
Office	80% of Allowed Benefit	70% of Allowed Benefit
In-vitro fertilization (IVF)	**Limitations** An approved Plan of Treatment is required. Benefits for in vitro fertilization (IVF) are limited to three attempts per live birth.	
Hospital/Outpatient facility	80% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	80% of Allowed Benefit	70% of Allowed Benefit
Office	80% of Allowed Benefit	70% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	**Out-of-Network**
Inpatient Provider Services	Subject to the requirements of PPACA, the Plan's payment for covered persons receiving inpatient benefits when the Group Contract renews will be the benefits in effect at the date of the inpatient admission (i.e., the benefits that apply to the Benefit Period during which the covered person was admitted, not the benefits that apply to any subsequent Benefit Period).	

SUMMARY PLAN DESCRIPTION
As of January 1, 2020

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Inpatient hospital or health care facility	**Limitations** Hospital Pre-Certification and Review is required. No prior authorization required for maternity admissions.	
	80% of Allowed Benefit	70% of Allowed Benefit
Skilled Nursing Facility	**Limitations** Hospital Pre-Certification and Review is required. Skilled Nursing Facility services are limited to 60 days per Benefit Period.	
	80% of Allowed Benefit	70% of Allowed Benefit
Health care practitioner - Inpatient medical care/surgery (except radiologists, pathologists, anesthesiologists, and surgical assistants)	80% of Allowed Benefit	70% of Allowed Benefit
Radiologist, pathologist, anesthesiologist, surgical assistant	80% of Allowed Benefit	Paid same as in-network

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Inpatient/Outpatient Provider Services		
Contraceptive exam, insertion and removal	No Deductible required 100% of Allowed Benefit	Benefits are available to the same extent as benefits provided for out-of-network outpatient medical care and surgery.
Cleft lip or cleft palate, or both		
Oral surgery		
Outpatient facility	80% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	80% of Allowed Benefit	70% of Allowed Benefit
Office	80% of Allowed Benefit	70% of Allowed Benefit
Orthodontics (office)	80% of Allowed Benefit	70% of Allowed Benefit

SUMMARY PLAN DESCRIPTION
As of January 1, 2020

Covered Service	CareFirst Payment	
	In-Network	**Out-of-Network**
Otological, audiological and speech/language treatment	Rehabilitative Services visit limits and Utilization Management Requirements for Speech Therapy, if any, do not apply.	
Outpatient facility	80% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	80% of Allowed Benefit	70% of Allowed Benefit
Office	80% of Allowed Benefit	70% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	**Out-of-Network**
Mastectomy-Related Services	Benefits are available to the same extent as benefits provided for other illnesses.	

Covered Service	CareFirst Payment	
	In-Network	**Out-of-Network**
Maternity services and newborn care	**Limitations** No prior authorization required for maternity admissions.	
Maternity services and newborn care except preventive prenatal services	Benefits are available to the same extent as benefits provided for inpatient and outpatient medical care in a hospital, facility, or office.	
Preventive Prenatal Services	No Deductible required 100% of Allowed Benefit	Benefits are available to the same extent as benefits provided for other illnesses.
Lactation support and counseling; Breastfeeding supplies and equipment	No Deductible required 100% of Allowed Benefit	Benefits are available to the same extent as benefits provided for other illnesses.

Covered Service	CareFirst Payment	
	In-Network	**Out-of-Network**
Medical Devices and Supplies		
Durable Medical Equipment	80% of Allowed Benefit	70% of Allowed Benefit

SUMMARY PLAN DESCRIPTION
As of January 1, 2020

Covered Service	CareFirst Payment	
	In-Network	**Out-of-Network**
Hair prosthesis	**Limitation** Benefits are limited to one (1) hair prosthesis per Benefit Period.	
	No Deductible required 100% of the Allowed Benefit	
Hearing Aids	**Limitations** Benefits for hearing aids are limited to a maximum of $1,000 per ear every 36 months.	
	80% of Allowed Benefit	70% of Allowed Benefit
Medical foods and nutritional substances	80% of Allowed Benefit	70% of Allowed Benefit
Medical Supplies	80% of Allowed Benefit	70% of Allowed Benefit
Orthotic Devices	80% of Allowed Benefit	70% of Allowed Benefit
Prosthetic Devices	80% of Allowed Benefit	70% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	**Out-of-Network**
Mental health and substance use disorder services, including behavioral health treatment	Subject to the requirements of PPACA, the CareFirst payment for covered persons receiving inpatient benefits when the Group Contract renews will be the benefits in effect at the date of the inpatient admission (i.e., the benefits that apply to the Benefit Period during which the covered person was admitted, not the benefits that apply to any subsequent Benefit Period).	
Inpatient Provider Services	**Limitations** Hospital Pre-Certification and Review is required.	
	80% of Allowed Benefit	70% of Allowed Benefit
Residential Crisis Services	80% of Allowed Benefit	70% of Allowed Benefit
Outpatient Provider Services		
Hospital	80% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	80% of Allowed Benefit	70% of Allowed Benefit
Office	No Deductible required 100% of Allowed Benefit after $10 Copay	70% of Allowed Benefit

SUMMARY PLAN DESCRIPTION
As of January 1, 2020

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Methadone Maintenance treatment	No Deductible required 100% of Allowed Benefit	No Deductible required 100% of Allowed Benefit
Outpatient psychological and neuropsychological testing for diagnostic purposes	Benefits are available to the same extent as outpatient Provider services for mental health and substance use disorder services, stated above.	
Emergency Services	Benefits are available to the same extent as Emergency Services benefits for other illnesses.	
Prescription Drugs	Benefits are available to the same extent as Prescription Drug benefits for other illnesses (i.e., where the medication is administered by a medical Provider and thus payable as a Physician and Provider benefit, not a Prescription Drug benefit).	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Non-Preventive Outpatient Diagnostic Services		
Laboratory tests		
Hospital/Outpatient facility	80% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	80% of Allowed Benefit	70% of Allowed Benefit
Office	80% of Allowed Benefit	70% of Allowed Benefit
X-ray and radiology services		
Hospital/Outpatient facility	80% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	80% of Allowed Benefit	70% of Allowed Benefit
Office	80% of Allowed Benefit	70% of Allowed Benefit
Other diagnostic services		
Hospital/Outpatient facility	80% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	80% of Allowed Benefit	70% of Allowed Benefit
Office	80% of Allowed Benefit	70% of Allowed Benefit

SUMMARY PLAN DESCRIPTION
As of January 1, 2020

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Organ and tissue transplants	**Limitations** Benefits are limited to the extent stated in the Organ and Tissue Transplant subsection of the Description of Covered Services. Hospital Pre-Certification and Review is not applicable to admissions for cornea and kidney transplants.	
Organ and tissue transplants	Benefits are available to the same extent as benefits provided for other illnesses.	
Organ transplant procurement	Benefits are available to the same extent as benefits provided for other illnesses.	
Organ transplant travel and lodging	Benefits are available to the same extent as benefits provided for other illnesses.	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Outpatient Provider Services		
Medical care and consultations (illness visits)		
Outpatient hospital/facility	80% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	80% of Allowed Benefit	70% of Allowed Benefit
Office/home	No Deductible required 100% of Allowed Benefit after $10 Copay	70% of Allowed Benefit
Urgent Care center	No Deductible required 100% of Allowed Benefit after $10 Copay	70% of Allowed Benefit
Telemedicine Services	Benefits are available to the same extent as benefits provided for outpatient medical care and consultations (illness visits), as stated above.	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Outpatient Provider Services		

SUMMARY PLAN DESCRIPTION
As of January 1, 2020

Covered Service	CareFirst Payment	
	In-Network	**Out-of-Network**
Outpatient Surgical Services		
Surgery		
Outpatient hospital/facility	80% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	80% of Allowed Benefit	70% of Allowed Benefit
Office	80% of Allowed Benefit	70% of Allowed Benefit
Ambulatory surgical facility services	80% of Allowed Benefit	70% of Allowed Benefit
Anesthesia	80% of Allowed Benefit	70% of Allowed Benefit
Surgical assistant	80% of Allowed Benefit	70% of Allowed Benefit
Female elective sterilization	No Deductible required 100% of Allowed Benefit	Benefits are available to the same extent as benefits provided for out-of-network outpatient medical care and surgery.
Male elective sterilization	Benefits are available to the same extent as benefits provided for outpatient medical care and surgery.	
Procedures to reverse sterilization	Benefits are available to the same extent as benefits provided for other surgical services.	

Covered Service	CareFirst Payment	
	In-Network	**Out-of-Network**
Outpatient Provider Services		
Acupuncture (office)	**Limitations** Acupuncture is limited to $1,000 maximum per Benefit Period.	
	80% of Allowed Benefit	70% of Allowed Benefit
Administration of injectable Prescription Drugs	80% of Allowed Benefit	70% of Allowed Benefit
Allergen immunotherapy (allergy injections)	No Deductible required 100% of Allowed Benefit After $5 Copay	70% of Allowed Benefit
Allergenic extracts (sera)	80% of Allowed Benefit	70% of Allowed Benefit
Allergy testing	80% of Allowed Benefit	70% of Allowed Benefit
Chemotherapy		

SUMMARY PLAN DESCRIPTION
As of January 1, 2020

Covered Service	CareFirst Payment	
	In-Network	**Out-of-Network**
Hospital/outpatient facility	80% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	80% of Allowed Benefit	70% of Allowed Benefit
Office	80% of Allowed Benefit	70% of Allowed Benefit
Chiropractic spinal manipulation	80% of Allowed Benefit	70% of Allowed Benefit
Hearing care		
Screening examination to diagnose hearing loss		
Hospital/outpatient facility	Benefits are available to the same extent as outpatient facility benefits provided for other illnesses.	
Outpatient professional practitioner	80% of Allowed Benefit	70% of Allowed Benefit
Office	80% of Allowed Benefit	70% of Allowed Benefit
Audiometric testing		
Hospital/outpatient facility	Benefits are available to the same extent as outpatient facility benefits provided for other illnesses.	
Outpatient professional practitioner	80% of Allowed Benefit	70% of Allowed Benefit
Office	80% of Allowed Benefit	70% of Allowed Benefit
Infusion Therapy		
Home	80% of Allowed Benefit	70% of Allowed Benefit
Inhalation therapy		
Hospital/facility	80% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	80% of Allowed Benefit	70% of Allowed Benefit
Office	80% of Allowed Benefit	70% of Allowed Benefit
Radiation therapy		
Hospital/facility	80% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	80% of Allowed Benefit	70% of Allowed Benefit
Office	80% of Allowed Benefit	70% of Allowed Benefit
Renal dialysis		
Hospital/facility	80% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	80% of Allowed Benefit	70% of Allowed Benefit
Office	80% of Allowed Benefit	70% of Allowed Benefit

SUMMARY PLAN DESCRIPTION
As of January 1, 2020

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Prescription Drugs	**Limitations** Benefits for Pharmacy-dispensed Prescription Drugs, intended for outpatient use, are stated in the Section of this Summary Plan Description entitled "Prescription Drug Benefits." Benefits under the medical portion of this Summary Plan Description are limited to Prescription Drugs dispensed in the office/place of services of a Provider.	
Injectable Prescription Drugs that require administration by a Provider	80% of Allowed Benefit	70% of Allowed Benefit
Prescription Drug contraceptives and contraceptive devices	No Deductible required 100% of Allowed Benefit	Benefits are available to the same extent as benefits provided for other illnesses.
Other Prescription Drugs	Benefits are available to the same extent as benefits provided for other illnesses.	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Professional Nutritional Counseling/Medical Nutrition Therapy		
All outpatient places of service	80% of Allowed Benefit	70% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Rehabilitative Services		
Inpatient Rehabilitative Services	**Limitations** Hospital Pre-Certification and Review is required.	
	80% of Allowed Benefit	70% of Allowed Benefit
Outpatient Rehabilitative Services		

SUMMARY PLAN DESCRIPTION
As of January 1, 2020

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Occupational Therapy		
Hospital/facility	80% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	80% of Allowed Benefit	70% of Allowed Benefit
Office	80% of Allowed Benefit	70% of Allowed Benefit
Physical Therapy		
Hospital/facility	80% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	80% of Allowed Benefit	70% of Allowed Benefit
Office	80% of Allowed Benefit	70% of Allowed Benefit
Speech Therapy		
Hospital/facility	80% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	80% of Allowed Benefit	70% of Allowed Benefit
Office	80% of Allowed Benefit	70% of Allowed Benefit
Cardiac Rehabilitation	**Limitations** Outpatient Cardiac Rehabilitation is limited to ninety (90) visits per Benefit Period.	
Hospital/facility	80% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	80% of Allowed Benefit	70% of Allowed Benefit
Pulmonary Rehabilitation	**Limitations** Pulmonary Rehabilitation benefits are limited to one (1) program per lifetime.	
Hospital/facility	80% of Allowed Benefit	70% of Allowed Benefit
Outpatient professional practitioner	80% of Allowed Benefit	70% of Allowed Benefit
Office	80% of Allowed Benefit	70% of Allowed Benefit
Visual Therapy		
Office	80% of Allowed Benefit	70% of Allowed Benefit

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Surgical treatment of Morbid Obesity	**Limitations** Benefits are limited to surgical treatment of Morbid Obesity services provided to the extent stated in the description of Covered Services.	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
	Benefits are available to the same extent as surgical benefits provided for other illnesses.	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Transgender Services	Benefits are available to the same extent as benefits provided for other inpatient and outpatient services.	

Covered Service	CareFirst Payment	
	In-Network	Out-of-Network
Vision Care services: routine vision exam	No Deductible required 100% of Allowed Benefit after $10 Copay	No Deductible required $33.00 CareFirst payment

More detailed information about the Schedule of Benefits is available without cost upon request from CareFirst Blue Cross Blue Shield at 800-628-8549.

SUMMARY PLAN DESCRIPTION
As of January 1, 2020

PRESCRIPTION DRUG BENEFITS

Please note: Fraudulent use of the prescription drug benefit by the Retiree or any eligible dependent amounts to theft, which will result in criminal prosecution and possible discharge from employment.

When you enroll in the CareFirst PPO Medical plan, you are automatically enrolled in the prescription drug benefit administered by CVS Caremark and will receive a CVS Caremark identification card. This card allows you to purchase most eligible drugs from a network of participating CVS Caremark pharmacies at a fixed copayment amount for each prescription.

Except in very few special circumstances, the prescription drug benefit administered by CVS Caremark does not cover prescription drugs that you receive in an inpatient setting or that are administered in a physician's office. These drugs are covered medical expenses under the CareFirst PPO Medical plan.

In general, an eligible prescription drug is a U.S. Food and Drug Administration-listed legend drug or compound medication that, under applicable state law, may only be dispensed upon the written prescription of a physician. Please be aware, however, that certain prescription drugs may not be covered by the Plan. An eligible drug must be Medically Necessary for the treatment of a disease or injury. In addition, while prescribed contraceptives are available under the Plan, they will be provided only through the CVS Caremark mail order pharmacy.

To see a complete list of covered drugs under the CVS Value Formulary, please visit https://www.caremark.com/portal/asset/Value_Formulary.pdf. The list of covered drugs may be adjusted at any time and for any reason.

Prescription Drug Program

The Plan's Prescription Drug Program has two parts:

The Retail Pharmacy Card – administered by CVS Caremark (PCS). You are provided with a prescription card, which is used for *acute* care treatment other than maintenance drugs. Non-maintenance medication is medication that is prescribed for short-term treatment (i.e., up to a 34-day supply with one refill only—for example, antibiotics, pain medication, etc.).

There is a co-pay for generic drugs and a higher co-pay for preferred

brand name and/or non-preferred brand name drugs. This Plan allows for a supply of prescription drugs up to 34 days plus one refill.

Mail Order Pharmacy – provided through CVS Caremark (PCS). The purchase of maintenance medications (i.e., those medicines that you take for long periods of time and refill regularly) and oral contraceptives are required to be filled through mail order.

There is a co-pay for generic drugs and a higher co-pay for brand name drugs. This plan allows for a supply of prescription drugs up to 90 days. Oral contraceptives are available through mail order only.

Eligibility for the Prescription Drug Plan

Only Retirees and their eligible dependents who are enrolled in the Plan may use the Retail Pharmacy and Mail Order Pharmacy. Unless otherwise required by law, your spouse or dependent (other than a surviving spouse or dependent) can enroll in the Plan's prescription drug plan only when you (the Retiree) can. Your spouse or dependent must enroll under the same coverage as you have. Once you are enrolled in the CareFirst PPO Medical Plan, you will receive a prescription drug ID card from CVS Caremark. You may request additional cards or have cards reissued by calling CVS Caremark directly at (800) 966-5772.

If you become covered under Medicare outpatient prescription drug coverage, this CVS Caremark outpatient drug coverage will terminate for you (and your spouse and other CVS Caremark enrolled dependents). Termination of your coverage will be effective at the end of the second month following the date on which the Plan learns you have Medicare drug coverage. The same rule applies if your spouse or other CVS Caremark enrolled dependent becomes covered by Medicare outpatient prescription drug coverage; in that case, you and all of your dependents' CVS Caremark coverage will be terminated as described above. Once CVS Caremark drug coverage has been terminated due to drug coverage under Medicare, you, your spouse, or your other dependents may not re-enroll in CVS Caremark coverage except in exceptional circumstances determined by the Plan Administrator. When you or any of your enrolled dependents signs up for Medicare outpatient prescription drug coverage or if you receive notice that the government has done so on your/their behalf, you must immediately notify the HR Service Center at 6801 Industrial Road, Springfield, VA 22151 or by phone at (703) 750-7779. This rule will not affect your other *medical* benefits under the Plan.

Using the Mail Order Pharmacy

To use the Mail Order Pharmacy, fill out the CVS Caremark order form (forms are

available from your Employer's Human Resources department or on the CVS Caremark website). Enclose your prescription(s), include your required co-pays, and mail the packet to CVS Caremark. CVS Caremark will mail your medicine to your home within 10 – 15 business days from the time it receives your prescription. Each time you receive a prescription you will also get a reorder form; simply call the toll-free number, go to www.caremark.com, or check off the medications you want to refill on the form and mail it back to CVS Caremark.

You also have the option of using CVS Caremark's "Fast Start Service." Registration for this service may be done online at http://info.caremark.com/faststart or by phone at (800) 875-0867. This service allows you to call CVS Caremark directly to obtain your mail order prescription. CVS Caremark will contact your physician and have him verify the medications you are trying to fill. You will need to provide CVS Caremark with your prescription card information, the name of the medication(s), and your physician's name and phone number.

PLEASE NOTE: If you do not want generic medications, your physician must specifically prescribe a brand name drug and indicate "Dispense as Written" ("DAW") on the prescription. If you request a brand name drug in the absence of the DAW directive, you will be responsible for paying the difference in price between the generic drug and the brand name drug.

Drug Step Therapy Program

The Plan's prescription drug program includes a "step therapy" program. Step therapy requires you to first try the most cost-efficient prescription drug treatment for your condition before using other drug therapies that are more expensive or difficult to use. The objective of the program is to ensure that patients are receiving appropriate, yet cost-effective, drug therapy. You may contact CVS Caremark to obtain a copy of a list of drugs included in the Plan's drug step therapy program. The drugs covered by the step therapy program may be adjusted at any time and for any reason.

Each of the drugs included in the drug step therapy program are divided into three categories. The categories are: (1) *generic* drugs; (2) *brand-name* drugs and (3) *preferred brand-name* drugs. Generic drugs are the least expensive drugs, while both categories of brand-name drugs are higher cost drugs. The step therapy program requires that patients first try a generic drug (category 1) or a preferred brand-name drug (category 3) before a brand-name drug (category 2) will be provided.

Physicians, pharmacists, and CVS Caremark work together to determine whether the drug prescribed for you is covered by the Plan's prescription drug step therapy program. First-time prescriptions for a particular treatment may require use of a generic drug or

preferred brand-name drug before you can switch to a brand-name drug. If a generic version of the medication does not exist, you will receive the brand-name drug as prescribed.

If you have any questions about the Plan's drug step therapy program, please contact CVS Caremark at 1-800-966-5772.

Prescription Benefit Guide

Schedule for Generic Step Therapy (GST)	**30-day supply at retail pharmacy**	**90-day supply at mail order/CVS**
Generic Drugs	$10 co-pay	$20 co-pay
Preferred brand drugs (not impacted by GST)	$15 co-pay	$30 co-pay
Non-preferred brand drugs (not impacted by GST)	80% coinsurance	80% coinsurance
Non-preferred brand (impacted by GST) **without** doctor's approval	Full cost of drug	Full cost of drug
Specialty Drugs	$75 co-pay	$100 co-pay

Certain prescription drugs classified as preventive services may be available without a co-payment in accordance with the Patient Protection and Affordable Care Act. Please contact CVS Caremark at 1-800-966-5772 for a list of drugs in this category.

There is a limit on the amount of out-of-pocket prescription drug expenses that you will be expected to incur for covered drugs each calendar year. This is called the out-of-pocket limit. After your costs reach the limit, the Plan will pay 100% of your eligible prescription drug costs (other than additional charges for "dispense as written" prescriptions). The annual out-of-pocket limit is $3,500 per individual and $7,000 per family. Additional charges for "dispense as written" premiums are not counted towards the out-of-pocket limit.

Any prescription with more than 1 refill, including maintenance medications, must be purchased through the CVS Caremark mail order pharmacy or through the 90-day supply prescription program that allows maintenance medication to be picked up from local CVS pharmacies.

Diabetic supplies and medications will be covered by CVS Caremark through the Mail Order Program for those who participate in the CareFirst PPO Plan.

Covered Drugs

The following drugs are covered by the Plan's prescription drug program when dispensed by a licensed pharmacist:

- Legend Drugs covered by the Plan. A "legend drug" is a medicine that requires a label bearing the legend "CAUTION: Federal Law Prohibits Dispensing Without a Prescription", or similar wording.
- Compounded medication of which at least one ingredient is a prescription legend drug.
- Insulin by prescription.
- Oral contraceptives (mail only and co-pay does not apply).
- Erectile dysfunction medications (prior authorization required).
- Preventive service medications required under the Patient Protection and Affordable Care Act.
- Any other drug covered by the Plan, which under the applicable state law, may only be dispensed upon the written prescription of a physician or other lawful prescriber.

Drugs Not Covered

The following drugs are not covered by your prescription drug plan:

- Drugs that are prescribed for weight loss, anabolic steroids and prescriptions for cosmetic reasons (i.e., hair loss and wrinkle treatments).
- Drugs furnished by a hospital, rest home, sanitarium or similar institution while the participant is confined at such institution.
- Non-legend drugs other than insulin, immunization agents, biological sera, blood or blood plasma, and vitamins, unless specifically provided for as covered drug charges.
- Any charges for administration of prescription legend drugs and injection of insulin.

- Any charges for therapeutic devices or appliances, including hypodermic needles, syringes, support garments and other non-medicinal substances, regardless of intended use. Some items may be covered under other parts of the medical plan. Please contact CareFirst for covered items.

- Any charge for any prescription refill in excess of the number specified by the physician or dentist or any refill dispensed more than one year from the date of the physician's or dentist's order.

- Any charges for which you are entitled to receive reimbursement under a Workers' Compensation law.

- Prescription legend drugs, which you are entitled to receive without charge from any municipal, state, or federal program.

- Drugs labeled "CAUTION: Limited by Federal Law to Investigational Use" or experimental drugs, even though a charge is made to the individual.

Claims Procedures and Appeals

This section describes the claims procedures used by the Prescription Drug Program.

Prior Authorization

The claims procedures for pre-service claims (described below) apply if you are required to obtain "prior authorization." A benefit requires prior authorization if the benefit will be reduced or denied if you do not obtain authorization prior to receiving the benefit. Below is a list of the drugs that require prior authorization. This list is subject to change at any time and without notice. For the most current list, contact CVS Caremark at (888) 413-2723. You can also access this information via its website at www.caremark.com.

Topical Acne (age >25)
ADD/Narcolepsy Drugs (age >25)
Anabolic Steroids
Growth Hormones
Interferons
Erectile Dysfunction Medication

If prior authorization for a particular drug is required, and you receive the prescription

without obtaining such authorization, the claims procedure for post-service claims (described below) will apply.

General Filing Requirements

CVS Caremark is the prescription drug claims administrator for the Plan's prescription drug program. All claims and appeals can be submitted to CVS Caremark at:

CVS Caremark
P.O. Box 52084
Phoenix, AZ 85072-2084
(866) 443-1172 (fax)

In light of the expedited time frames for decision of "urgent care" claims (as described below), an urgent care claim for benefits may instead be submitted to CVS Caremark by phone at (866) 443-1183 or by fax at (866) 443-1172.

Your claim should include at least the following: the identity of the claimant; the specific medical problem or issue; and the specific treatment, service, or product for which approval or payment is requested.

- If you have a concern regarding an adverse benefit determination, you may call CVS Caremark at (800) 966-5772. Working with a CVS Caremark Customer Care representative may resolve most issues quickly and satisfactorily.

- Oral inquiries about coverage and benefits are not considered claims or appeals, unless specifically noted.

- Except for appeals involving urgent claims, all appeals must be submitted in writing. Appeals of urgent claims may be submitted either orally or in writing.

- All time periods described in the section are in calendar days, not business days.

- An authorized representative may file claims and appeals on your behalf. For the post-service claims procedure, you must complete an authorized representative form, which is available by calling CVS Caremark, in order for another person to represent you. For the pre-service and urgent care claims procedure, your healthcare provider or physician will be recognized

as your authorized representative unless you direct otherwise. Once an authorized representative is appointed, all information, notices, etc., regarding your claim will be directed to your authorized representative. You will be copied on all notifications regarding decisions unless specific written instructions direct otherwise.

- If you do not file a claim or follow the Plan's claim procedures correctly, you may be giving up important legal rights.

Filing an Initial Claim

Time for Filing a Claim

Your claim must be received by CVS Caremark no later than June 30th of the first year following the year in which you received the service or supply at issue.

Filing a Claim

Generally, when you fill a prescription at a participating pharmacy, including a mail-order pharmacy, you do not need to file a claim. Rather, a participating pharmacy will electronically submit your initial claim directly to CVS Caremark and payment will be made directly to them. You are responsible for paying any copayment directly to the pharmacy. In some instances, you may need to pay your pharmacy in full and then submit a claim for reimbursement to CVS Caremark at the address indicated on the form. You will need to file a claim form if:

- You are purchasing a prescription "out-of-network" (rare);
- You forget your prescription card when you pick up your medication at a participating pharmacy; or
- You, your spouse, or dependents have primary coverage under another medical plan.

You can obtain a claim form from:

- Employee Benefits
- The CVS Caremark website at www.caremark.com
- Or by calling CVS Caremark at (800) 966-5772

If you present a prescription to the pharmacist and are told that the drug is not covered or you disagree with the amount you are required to pay, you can either (1) pay for the prescription and then file a claim for reimbursement, or (2) file a claim for benefits before having the prescription filled. In either case, the procedure for filing a claim for reimbursement, described above, must be followed.

Claim Denial and Appeal Procedures

If a claim for benefits under the Prescription Drug Program is denied either in whole or in part, you or your dependents have certain rights as outlined below.

Benefit Determinations: Pre-Service Claims

Pre-service claims are those claims that require notification or approval before you can receive the medical benefit. Prior authorization requests are typically pre-service claims. If your claim was a pre-service claim and was submitted properly with all necessary information, you will receive a written or electronic notice of the claim decision from CVS Caremark within a reasonable time period appropriate to the circumstances, but not later than 15 days from receipt of the claim.

If you filed a non-urgent pre-service claim incorrectly, CVS Caremark will notify you of the incorrect filing and how to correct it within five days after the pre-service claim was received. Notice may be oral unless written notification is specifically requested. In order to receive notice of an incorrectly filed pre-service claim, you or your authorized representative must have provided information regarding your claim to CVS Caremark, and the information must include the identity of you or your authorized representative, the specific problem or issue, and a request for approval of the specific product or service.

You may be notified that an extension of up to 15 days is needed to decide your claim due to reasons beyond the control of CVS Caremark. The extension notice will specify the circumstances requiring the extension and the expected date of determination. If the extension is necessary because you need to provide additional information in order for your claim to be decided, you will be given at least 45 days to provide that information. The time it takes you to provide that information will not count against the time that CVS Caremark has to make its decision. If you don't provide the needed information within the 45-day period, your claim will be denied. A denial notice will include the information described below under the section entitled "Claim Decision."

Benefit Determinations: Post-Service Claims

Post-service claims are those claims for which the claimant has received medication and is requesting reimbursement. If your post-service claim is denied, you or your duly authorized representative will receive a written or electronic notice from CVS Caremark within a reasonable period of time, but not later than 30 days after receipt of the claim, as long as all needed information was provided with the claim.

You may be notified that an extension of up to 15 days is needed to decide your claim due to reasons beyond the control of CVS Caremark. The extension notice will specify the circumstances requiring the extension and the expected date of determination. If the extension is required because you need to provide additional information in order for your claim to be decided, you will be given at least 45 days to provide that information. The time it takes you to provide that information will not count against the time that CVS Caremark has to make a decision. If all of the needed information is received within the 45-day time frame and the claim is denied, CVS Caremark will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied. A denial notice will include the information described below under the section entitled "Claim Decision."

Benefit Determinations: Urgent Claims Requiring Immediate Action

If you or your doctor believe your situation is "urgent" as defined by law (that is, your health is in serious jeopardy or, in the opinion of your doctor, you will experience pain that cannot be adequately controlled while you wait for a decision on your appeal), you will receive notice of the benefit determination in writing or electronically as soon as possible (taking into account the medical exigencies), but not later than 72 hours after CVS Caremark receives your claim.

If you fail to follow the procedures for filing a claim involving urgent care, CVS Caremark will notify you how to correct it as soon as possible, but no later than 24 hours following CVS Caremark's receipt of the incorrectly filed claim. Notice may be oral unless written notification is specifically requested. In order to receive notice of an incorrectly filed urgent care claim, you or your authorized representative must have provided information regarding your claim to CVS Caremark, and the information must include the identity of you or your authorized representative, the specific problem or issue, and a request for approval of the specific product or service.

If the information included in your urgent care claim is incomplete, CVS Caremark will notify you of the incomplete filing and how to correct it as soon as possible, but no later than 24 hours following receipt of the incomplete claim. You will then have a reasonable amount of time, taking into account your circumstances, but not less than 48 hours to provide the requested information. You will be notified of a determination as soon as possible, but in no event later than 48 hours after the earlier of (a) receipt of the requested

information, or (b) the end of the period of time given to the claimant to submit the specified information.

A denial notice will include the information described below under the section entitled “Claim Decision,” as well as a description of any expedited review process applicable to your claim. Notice of denial of an urgent care claim may be oral with a written or electronic confirmation to follow within three days.

Benefit Determinations: Concurrent Care

If an ongoing course of treatment has been approved to be provided over a period of time or number of treatments:

- Any reduction or termination of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments shall constitute a denial. You will be notified of the denial at a time sufficiently in advance of the reduction or termination to allow you to file an appeal and obtain a determination on review of the denial before the benefit is reduced or terminated.

- Any request by you to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care shall be decided as soon as possible, taking into account the medical exigencies. You will be notified of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim, provided that any such claim is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Notification of any denial concerning a request to extend the course of treatment, whether involving urgent care or not, shall be made in accordance with the procedures noted under “Claim Decision” below, and appeal shall be governed by the procedures noted herein as appropriate.

- Continued coverage will be provided pending the outcome of an Appeal.

Claim Decision

You will receive notification of an adverse determination in writing or electronically if either your request for prior authorization or the claim you submitted is denied. The denial notice will include:

- The specific reason or reasons for denial with reference to those specific plan provisions on which the denial is based;

- A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary.

- A description of the Prescription Drug Program's procedures for appeal of the denial of a claim, including a statement of your right to bring a civil action under Section 502(a) of ERISA if the first and second level of appeals are denied, as well as a statement regarding your possible rights to external review (as mandated by the Patient Protection and Affordable Care Act of 2010 (the "ACA"));

- Identification of, or information about how to obtain, any internal rule, guideline, protocol relied upon in making the decision, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon and a copy thereof will be provided free of charge upon request;

- If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the decision or information about how to obtain such explanation.

- In the case of a denial concerning a claim involving urgent care, a description of the expedited review process applicable to such claims.

How To Appeal A Claim Decision

If you disagree with an adverse claim determination, you or your authorized representative can contact CVS Caremark to formally request an appeal. Your appeal must be submitted to CVS Caremark in writing no later than 180 days after you receive notice of an adverse decision. Requests for an appeal may be submitted in writing by fax or mail. You or your authorized representative may, however, request an appeal of an urgent care claim by phone. CVS Caremark should be contacted as soon as possible when your appeal involves a claim for urgent care. In the case of a claim involving urgent care, a request for an expedited review may be submitted orally or in writing by you, and all necessary information shall be transmitted between CVS Caremark and you by telephone, facsimile, or other available similarly expeditious method.

Denials of requests for prior authorization of benefits are subject to two levels of appeal. If your request for benefits is denied at the first level of appeal, you or your authorized representative have the right to request a second level of appeal. Your second level appeal request must be submitted within 60 days from receipt of the first level appeal

decision. Both the first and second levels of appeal will follow the procedures described below. The review at the second level of appeal will afford no deference to the first level adverse determination and will not be made by either the individual who made a prior adverse determination nor the subordinate of such individual.

Generally, you must fully exhaust the internal remedies provided by these claims procedures prior to filing a suit or requesting ACA-mandated external review (if your claim is eligible).

When appealing a denial of your claim for benefits, you have the right to:

- Submit written comments, documents, records and other information relating to the claim;
- Request, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim that:
  - the reviewer relied on in making the determination,
  - was submitted, considered, or generated in the course of making the benefit determination,
  - demonstrates compliance with the administrative processes and safeguards required in making the determination, or
  - constitutes a statement of policy or guidance with respect to the Prescription Drug Program concerning the denied treatment or benefit without regard to whether the statement was relied upon;
- A review that takes into account all comments, documents, records, and other information submitted by you or your authorized representative, without regard to whether such information was submitted or considered in the initial claim decision;
- A review that does not defer to the initial adverse decision and is not conducted by the individual who made the adverse decision or the subordinate of such individual;
- If the appeal involves an adverse decision based on medical judgment, a review of your claim by a health care professional who has appropriate training and experience in the field of medicine involved in the medical

judgment, and who was neither consulted in connection with the adverse decision nor the subordinate of any such individual; and

- If requested, the identification of medical or vocational experts, if any, consulted in connection with the claim denial, without regard to whether the advice was relied upon in making the decision.

- Full and fair review – CVS Caremark will allow you to review the claim file and to present evidence and testimony as part of the internal claims and appeals process. Specifically, in addition to the requirements above, the following apply:

  - CVS Caremark will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by CVS Caremark (or at the direction of CVS Caremark) in connection with the claim; such evidence will be provided as soon as possible and sufficiently in advance of the date on which the determination is required to be provided, to give you a reasonable opportunity to respond prior to that date; and

  - Before CVS Caremark issues a final internal adverse benefit determination based on a new or additional rationale, you will be provided, free of charge, with the rationale; the rationale will be provided as soon as possible and sufficiently in advance of the date on which the determination is required to be provided, to give you a reasonable opportunity to respond prior to that date.

- Avoiding conflicts of interest – In addition to the requirements above regarding full and fair review, CVS Caremark will ensure that all claims and Appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.

Claim Appeal Process

You or your authorized representative will be provided written or electronic notification (or notification by some other expeditious method with respect to certain urgent care claims) of the decision on your appeal as follows:

- ***For appeals of pre-service claims***, within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days after receipt by CVS Caremark of the request for appeal. If a second level of appeal will be conducted, you will be notified within 15 days from receipt by CVS Caremark of a request for review of the first level of appeal.

- ***For appeals of post-service claims***, within a reasonable period of time, but no later than 30 days after receipt by CVS Caremark of a request for appeal. If a second level of appeal will be conducted, you will be notified within 30 days from receipt by CVS Caremark of a request for review of the first level of appeal.

- ***For appeals of urgent care claims***, as soon as possible taking into account the specific exigencies, but no later than 72 hours after receipt by CVS Caremark of the request for appeal. If a second level of appeal will be conducted, you will be notified within 72 hours from receipt by CVS Caremark of your initial request for appeal. Thus, the total period for completing two levels of review will not exceed the maximum 72-hour period applicable to a claim with only one level of review.

The period of time within which a decision on appeal is required to be made shall begin at the time a claim is filed in accordance with these procedures, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended as described above due to your failure to submit information necessary to decide a claim, the period for making the benefit determination will be tolled from the date the extension notice is sent to you until the date on which you respond to the request for additional information.

Decision on Appeal

Written notice of an adverse decision on appeal shall include:

- The specific reasons for the denial with reference to the specific plan provisions on which the denial is based;

- A statement that you are entitled to receive, upon request and free of charge, reasonable access to or copies of all documents, records, and other information that:

  - was relied on in making the determination,

    - was submitted, considered, or generated in the course of making the benefit determination,
    - demonstrates compliance with the administrative processes and safeguards required in making the determination, or
    - constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment or benefit without regard to whether the statement was relied upon;

- A statement describing the voluntary appeal procedures available to you (if any) and your right to obtain further information about such procedures;
- A statement of your right to bring an action under section 502(a) of ERISA and your right to request ACA-mandated external review (if your claim is eligible);
- If applicable, any internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse decision, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon and a copy thereof will be provided free of charge upon request; and
- If the adverse decision was based on a medical necessity, experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment for the adverse decision, or a statement that such explanation will be provided free of charge upon request.

Notification of an adverse decision on appeal of an urgent care claim may be provided to you orally, but written notification shall be furnished not later than three days after the oral notice.

The appeal of an adverse benefit decision will be reviewed and decided by CVS Caremark as the claims fiduciary responsible for deciding appeals under the Prescription Drug Program. With respect to such reviews, CVS Caremark shall have the sole and absolute discretion to interpret the Plan's Prescription Drug Program and to make factual findings. The decision of CVS Caremark shall be final, subject to judicial review only for abuse of discretion. CVS Caremark's decision on appeal may also be subject to ACA-mandated external review, as described below.

Notice Requirements

- Notices provided by CVS Caremark will be provided in a culturally and linguistically appropriate manner. In addition:
    - CVS Caremark will ensure that any notice of adverse benefit determination or final internal adverse benefit determination includes information sufficient to identify the claim involved (including, as applicable, the date of service, the Provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).
    - CVS Caremark will provide to you, as soon as practicable and as applicable, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, associated with any adverse benefit determination or final internal adverse benefit determination. CVS Caremark will not consider a request for such diagnosis and treatment information, in itself, to be a request for an internal appeal or an external review (described below).
    - CVS Caremark will ensure that the reason or reasons for the adverse benefit determination or final internal adverse benefit determination includes, as applicable, the denial code and its corresponding meaning, as well as a description of CVS Caremark's standard, if any, that was used in denying the claim. In the case of a notice of final internal adverse benefit determination, this description must include a discussion of the decision.
    - CVS Caremark will provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal.
    - CVS Caremark will disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793 to assist individuals with the internal claims and appeals and external review processes.

Request for External Review

If you receive a "Final Internal Adverse Determination" (as defined below) of a "Claim" for prescription drug benefits you may request an external review of your claim following the procedures described below.

Definitions

For the purposes of this external review section, the following terms apply:

- ***Adverse Benefit Determination*** means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a prescription drug plan benefit. Such denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) may apply to both clinical and non-clinical determinations. However, only Adverse Benefit Determinations of a Claim Involving Medical Judgment are eligible for external review.

- ***Claim*** means a request for a prescription drug plan benefit that is made in accordance with the Plan's established procedures for filing benefit claims.

- ***Final Internal Adverse Benefit Determination*** means an Adverse Benefit Determination that has been upheld by the Plan at the completion of the internal appeals process, or an Adverse Benefit Determination with respect to which the internal appeals process has been deemed exhausted.

- ***Independent Review Organization (IRO***) means an entity that conducts independent external reviews of Adverse Benefit Determinations and Final Internal Adverse Benefit Determinations.

- ***Claim Involving Medical Judgment*** means a Claim for prescription drug benefits involving, but not limited to, decisions based on the Plan's standards for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or involving determinations as to whether a treatment is experimental or investigational.

Federal External Review Process (Non-Expedited)

Request for Review

If your Claim Involving Medical Judgment is denied, you may request, in writing, an external review of such Claim within 4 months after receiving notice of the Final Internal Adverse Benefit Determination. Your request should include your name, contact information including mailing address and daytime phone number, your member ID number, and a copy of the coverage denial. Your request for external review and supporting documentation may be mailed or faxed to CVS Caremark:

CVS Caremark
External Review Appeals Department
MC109
P.O. Box 52084
Phoenix, AZ 85072-2084
Fax Number: 1-866-689-3092

Preliminary Review:

Within 5 days of receiving your request for external review, CVS Caremark will conduct a "preliminary review" to ensure that your request qualifies for external review. In this preliminary review, CVS Caremark will determine whether:

- You are or were covered under the Plan at the time the prescription drug benefit at issue was requested, or in the case of a retrospective review, were covered at the time the prescription drug benefit was provided;
- The Adverse Benefit Determination or Final Internal Adverse Benefit Determination does not relate to your failure to meet the Plan's requirements for eligibility (for example, worker classification or similar determinations), as such determinations are not eligible for ACA-mandated external review;
- You have exhausted the Plan's internal appeal process (unless your Claim is "deemed exhausted"); and
- You have provided all the information and forms necessary to process the external review.

In addition, CVS Caremark will review your request for external review to determine whether it involves a Claim Involving Medical Judgment. If CVS Caremark determines that your request does not involve a Claim Involving Medical Judgment, it will forward your request for external review to an IRO for further review. The IRO will determine whether your request for external review involves a Claim Involving Medical Judgment as soon as possible.

Within one business day after completing its preliminary review, CVS Caremark will notify you, in writing, that: (i) your request for external review is complete, and may proceed; (ii) your request is not complete, and additional information is needed (along with a list of the information needed to complete the request; a claimant will be allowed to perfect the request within the four-month filing period or within the 48-hour period following the receipt of the notification, whichever is later); or (iii) the request for external review is

complete, but not eligible for review (such notice must include the reasons for its ineligibility and current contact information, including the phone number, for the Employee Benefits Security Administration).

Referral to IRO:

If your request for external review is complete and your Claim is eligible for external review, CVS Caremark will assign the request to one of the IROs with which CVS Caremark has contracted. The IRO will notify you of its acceptance of the assignment. You will then have 10 business days to provide the IRO with any additional information you want the IRO to consider.

Within five business days after the date of assignment of the IRO, CVS Caremark shall provide to the assigned IRO the documents and any information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Failure by CVS Caremark to timely provide the documents and information will not delay the conduct of the external review. If CVS Caremark fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Within one business day after making the decision, the IRO shall notify you and CVS Caremark.

Upon receipt of any information submitted by you, the assigned IRO shall within one business day forward the information to CVS Caremark. Upon receipt of any such information, CVS Caremark may reconsider its Adverse Benefit Determination or Final Internal Adverse Benefit Determination that is the subject of the external review. Reconsideration by CVS Caremark shall not delay the external review. The external review may be terminated as a result of the reconsideration only if CVS Caremark decides, upon completion of its reconsideration, to reverse its Adverse Benefit Determination or Final Internal Adverse Benefit Determination and provide coverage or payment. Within one business day after making such a decision, CVS Caremark shall provide written Notice of its decision to you and the assigned IRO. The assigned IRO shall terminate the external review upon receipt of such notice from CVS Caremark.

The IRO will conduct its external review without giving any consideration to any earlier determinations made on behalf of the Plan. The IRO may consider information beyond the records for your denied Claim, such as:

- Your medical records;
- Your attending health care professional's recommendations;

- Any applicable clinical review criteria developed and used on behalf of the Plan (unless the criteria are inconsistent with the terms of the Plan or applicable law);

- The opinion of the IRO's clinical reviewer(s) after considering all information and documents applicable to your request for external review, to the extent such information or documents are available and the IRO's clinical reviewer(s) considers it appropriate;

- Reports from appropriate health care professionals and other documents submitted by the Plan, the covered person, or the covered person's treating physician;

- The terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the plan (unless those terms are inconsistent with applicable law); and

- Appropriate practice guidelines, which must include applicable evidence based standards and may include any other practice guidelines developed by the Federal government, national or professional medicine societies, boards, and associations.

Timing of IRO's Determination:

The IRO will provide you and CVS Caremark (on behalf of the Plan) with written notice of its final external review decision within 45 days after the IRO receives the request for external review. The IRO's notice will contain:

- A general description of the reason for the request for external review, including information sufficient to identify the Claim (including the date or dates of service, the Provider, the claim amount (if applicable), and the reasons for the previous denials);

- The date the IRO received the external review assignment from CVS Caremark, and the date of the IRO's decision;

- References to the evidence or documentation, including specific coverage provisions and evidence-based standards, the IRO considered in making its determination;

- A discussion of the principal reason(s) for the IRO's decision, including the rationale for the decision, and any evidence-based standards that were relied upon by the IRO in making its decision;

- A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Plan or to you;

- A statement that you may still be eligible to seek judicial review of any adverse external review determination; and

- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsmen available to assist you.

Reversal of the Plan's Prior Decision:

If CVS Caremark receives notice from the IRO that it has reversed the prior adverse determination of your Claim, CVS Caremark will immediately provide coverage or payment for the Claim.

Federal External Review Process (Expedited)

You may request an expedited ACA-mandated external review:

- If you receive an Adverse Benefit Determination related to a Claim Involving Medical Judgment that involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health, and/or could result in your failure to regain maximum function, and you have filed a request for an expedited internal appeal; or

- If you receive a Final Internal Adverse Benefit Determination related to a Claim Involving Medical Judgment that involves: (i) a medical condition for which the timeframe for completion of a standard ACA-mandated external review would seriously jeopardize your life or health, and/or could result in your failure to regain maximum function; or (ii) an admission, availability of care, continued stay, or a prescription drug benefit for which you have received emergency services, but have not been discharged from a facility.

Request for Review:

If your situation meets the definition of urgent under the law, the external review of the Claim will be conducted as expeditiously as possible. In that case, you or your physician may request an expedited external review by calling Customer Care toll-free at the number on your benefit ID card or contacting your benefits office. The request should

include your name, contact information including mailing address and daytime phone number, member ID number, and a description of the coverage denial.

Alternatively, a request for expedited external review may be faxed; your contact information and coverage denial description, and supporting documentation may be faxed to the attention CVS Caremark External Review Appeals Department at fax number 1-866-689-3092.

Preliminary Review

Immediately on receipt of your request for expedited external review, CVS Caremark will determine whether the request meets the reviewability requirements described above for standard external review. Immediately upon completing this review, CVS Caremark will notify you that: (i) your request for external review is complete, and may proceed; (ii) the request is not complete, and additional information is needed (along with a list of the information needed to complete the request); or (iii) the request is complete, but not eligible for review.

Referral to IRO

Upon determining that your request is eligible for expedited external review, CVS Caremark will assign an IRO to review your Claim. CVS Caremark will provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Adverse Benefit Determination to the assigned IRO electronically, by telephone, by fax, or by any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information and documents described above. In reaching a decision on an expedited request for external review, the IRO will review your Claim de novo and will not be bound by the decisions or conclusions reached on behalf of the Plan during the internal claims and appeals process.

Timing of the IRO's Determination

The IRO must provide you and CVS Caremark, on behalf of the Plan, with notice of its determination as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives your request for external review. If this notice is not provided in writing, within 48 hours after providing the notice, the IRO will provide you and CVS Caremark, on behalf of the Plan, with written confirmation of its decision.

Authority for Review

CVS Caremark is responsible only for conducting the preliminary review of your request for external review, ensuring that you are timely notified of the decision as to eligibility for external review, and for assigning the request for external review to an IRO.

The actual external review of your appeal will be conducted by the assigned IRO. CVS Caremark is not responsible for the conduct of the external review performed by an IRO.

APPENDIX A

IMPORTANT NOTICES ABOUT YOUR RIGHTS UNDER THE PLAN

- Notice of Privacy Practices
- Special Rights on Childbirth
- Important Notice from Washington Gas Light Company About Your Prescription Drug Coverage and Medicare

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

This Notice of Privacy Practices describes how the self-insured group health plans that are sponsored by Washington Gas Light Company ("Washington Gas" or the "Company"), such as the CareFirst PPO Medical Plan, the CareFirst CDHP Plan, Prescription Drug Program, and Retiree Dental Care Plan components of the Washington Gas Light Company Employees Group Medical Plan and the Washington Gas Light Company Retiree Medical Plan, the Prescription Drug Plan, the Washington Gas Light Company Dental Care Plan, the Health Care Account component of the Washington Gas Light Company Flexible Spending Account Plan, and the Washington Gas Light Company Employee Assistance Program (each referred to in this Notice as a "Plan," and together "the Plans") and any third party that assists in the administration of the Plans may use and disclose your protected health information.

Washington Gas sponsors these Plans. Employees of Washington Gas Energy Services, Washington Gas Energy Systems, Hampshire Gas, AltaGas Power Holdings (U.S.) Inc., and AltaGas Services (U.S.) Inc. also participate in some of these Plans, along with other employers designated by Washington Gas.

This Notice also sets out the Plans' legal obligations concerning your protected health information and describes your rights to access and control your protected health information.

If you are covered under one of the Company's insured medical plans, such as the vision care plan, the HMO or the DHMO, you will receive a similar notice from the insurance carrier or the HMO regarding your protected health information under the insured health plan or HMO. The notice from the insurance carrier of HMO will cover the privacy practices under the insured plan or HMO.

Our Legal Duty

This notice describes our privacy practices, which include how we might use, disclose (share or give out), collect, handle, and protect your protected health information. We are required by certain federal and state laws to maintain the privacy of your protected health information. We are also required to provide you with certain rights with respect to your protected health information, to give you this notice about our privacy practices, our legal duties,

and your rights concerning your protected health information, and to abide by the terms of this notice. In addition, we are required to notify you if a breach of your unsecured protected health information occurs. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect October 1, 2019 and is not intended to amend any prior notice of Washington Gas Light Company's privacy practices.

We reserve the right to change our privacy practices and the terms of this notice at any time, as long as the law permits the changes. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all protected health information that we maintain, including protected health information we created or received before we made the changes. If we make a significant change in our privacy practices, we will change this notice and notify health plan participants within sixty days of the effective date of the change.

You may request a copy of this notice at any time. For additional copies, please contact the Company's Employee Benefits Department using the information listed at the end of this notice.

Uses and Disclosures of Medical Information

Primary Uses and Disclosures of Protected Health Information

The federal health care privacy regulations (referred to as the "Federal Privacy Regulations") under the Health Insurance Portability and Accountability Act ("HIPAA") protect only certain medical information known as "protected health information." Generally, protected health information is health information, including demographic information, collected from you or created or received by a Health Care Provider, a health care clearinghouse, a health plan or your employer on behalf of a group health plan, from which it is possible to individually identify you and that relates to (1) your past, present, or future physical or mental health or condition, (2) the provision of health care to you, or (3) the past, present, or future payment for the provision of health care to you.

We may use and disclose protected health information about you for payment and health care operations. The Federal Privacy Regulations generally do not "preempt" (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the Federal Privacy Regulations, might impose a privacy standard under which we will be required to operate. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of the protected health information concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, and reproductive rights. In addition to these state law requirements, we also may use or disclose protected health information in the following situations:

Payment: We might use and disclose your protected health information for all activities that are included within the definition of "payment" as written in the Federal Privacy Regulations. For example, we might use and disclose your protected health information to pay claims for services provided to you by doctors, hospitals, pharmacies and others for services delivered to you that are covered by your health plan. We might also use your information to determine your eligibility for benefits, to coordinate benefits, to examine medical necessity, to obtain premiums, and to issue explanations of benefits to the person who subscribes to the health plan in which you participate.

Health Care Operations: We might use and disclose your protected health information for all activities that are included within the definition of "health care operations" as defined in the Federal Privacy Regulations. For example, we might use and disclose your protected health information to monitor the third party administrators to ensure that they are properly and accurately paying claims in accordance with the terms of the health plan documents, when reviewing claims appeals, to determine our costs for your health plan, to conduct quality assessment and improvement activities, to engage in care coordination or case management, and to manage our business.

Business Associates: In connection with our payment and health care operations activities, we contract with individuals and entities (called "business associates") to perform various functions on our behalf or to provide certain types of services (such as member service support, utilization management, subrogation, or pharmacy benefit management). To perform these functions or to provide these services, business associates will receive, create, maintain, use, or disclose protected health information, but only after we require the business associates to agree in writing to contract terms designed to appropriately safeguard your information.

Other Covered Entities. In addition, we might use or disclose your protected health information to assist Health Care Providers in connection with *their* treatment or payment activities, or to assist other covered entities in connection with certain of *their* health care operations. For example, we might disclose your protected health information to a Health Care Provider when needed by the provider to render treatment to you, and we might disclose protected health information to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities, or accreditation, certification, licensing or credentialing.

<u>Other Possible Uses and Disclosures of Protected Health Information</u>

The following is a description of other possible ways in which we might (and are permitted to) use and/or disclose your protected health information.

To You or with Your Authorization: We must disclose your protected health information to you, as described in the Individual Rights section of this notice. You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose

not listed on this notice. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures that we made as permitted by your authorization while it was in effect. Without your written authorization, we might not use or disclose your protected health information for any reason except those described in this notice.

Disclosures to the Secretary of the U.S. Department of Health and Human Services: We are required to disclose your protected health information to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with the Federal Privacy Regulations.

To the Company as Plan Sponsor: Where permitted by law, we may disclose your protected health information to certain employees of the Company to perform plan administration functions. For example, the Company may be seeking information to evaluate future changes to a Plan. Summary health information (this type of information is defined in the Federal Privacy Regulations) may also be disclosed about the enrollees in a Plan to the Company to obtain bids for the health coverage offered through your group health plan or to decide whether to modify, amend or terminate the Plan.

To Family and Friends: We might disclose your protected health information to a family member, friend or other person directly involved with your health care or with payment for your health care, as permitted by HIPAA. In addition, we may notify a family member or other individual involved in your care of your location, general condition, or death - or may notify a public or private entity authorized by law or its charter to assist in disaster relief efforts to make such notifications.

Underwriting: We might receive your protected health information for underwriting, premium rating or other activities relating to the creation, renewal or replacement of a contract for health benefits. We will not use or further disclose this protected health information received under these circumstances for any other purpose, except as required by law, unless and until a contract of health benefits is entered into. Further, we will not use your genetic information for underwriting purposes.

Health Oversight Activities: We might disclose your protected health information to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee: (1) the health care system; (2) government benefit programs; (3) other government regulatory programs; and (4) compliance with civil rights laws.

Abuse or Neglect: We might disclose your protected health information to appropriate authorities if we reasonably believe that you might be a possible victim of abuse, neglect, domestic violence or other crimes.

Public Health Risks: We might disclose your protected health information for public health activities. These activities generally include the following: to prevent

or control disease, injury, or disability; to report births and deaths; to report child abuse and neglect; to report reactions to medications or problems with products; to notify people of recalls of products they may be using; or to notify a person who may be exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Coroners, Medical Examiners, Funeral Directors, and Organ Donation: We might disclose protected health information to a coroner or medical examiner for purposes of identifying you after you die, determining your cause of death, or for the coroner or medical examiner to perform other duties authorized by law. We also might disclose, as authorized by law, information to funeral directors so that they may carry out their duties on your behalf. Further, we might disclose protected health information to organizations that handle organ, eye, or tissue donation and transplantation.

Research: We might disclose your protected health information to researchers when an institutional review board or privacy board has: (1) reviewed the research proposal and established protocols to ensure the privacy of the information; and (2) approved the research.

Inmates: If you are an inmate of a correctional institution, we might disclose your protected health information to the correctional institution or to a law enforcement official for: (1) the institution to provide health care to you; (2) your health and safety and the health and safety of others; or (3) the safety and security of the correctional institution.

Workers' Compensation: We might disclose your protected health information to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

Public Health and Safety: We might disclose your protected health information to the extent necessary to avert a serious and imminent threat to your health or safety or the health or safety of others.

Required by Law: We might use or disclose your protected health information when we are required to do so by law. For example, we must disclose your protected health information to the U.S. Department of Health and Human Services upon their request for purposes of determining whether we are in compliance with federal privacy laws.

Legal Process and Proceedings: We might disclose your protected health information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we might disclose your protected health information to law enforcement officials.

Law Enforcement: We might disclose to a law enforcement official limited protected health information of a suspect, fugitive, material witness, crime victim, or missing person. We might disclose protected health information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has

escaped from lawful custody.

Military and National Security: We might disclose to military authorities the protected health information of Armed Forces personnel under certain circumstances. We might disclose to federal officials protected health information required for lawful intelligence, counterintelligence, and other national security activities.

Other Uses and Disclosures of Your Protected Health Information

Other uses and disclosures of your protected health information that are not described above will be made only with your written authorization. If you provide us with such an authorization, you may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of protected health information. However, the revocation will not be effective for information that we already have used or disclosed in reliance on your authorization.

We will disclose your protected health information to your personal representative if you provide us with a written notice or authorization and any supporting documents that we may reasonably request. In general and subject to specific conditions, unless you give us a written authorization, we will not use or disclose your psychotherapy notes; we will not use or disclose your protected health information for marketing purposes; and we will not sell your protected health information.

Individual Rights

Access: You have the right to look at or get copies of the protected health information contained in a designated record set, with limited exceptions. You may request that we provide copies in a format other than photocopies, including electronic format for information stored in such format. We will use the format you request where readily producible. You must make a request in writing to obtain access to your protected health information. You may obtain a form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the address at the end of this notice. If you request copies, we might charge you a reasonable cost-based fee for each page, and postage if you want the copies mailed to you. If you request an alternative format, we might charge a cost-based fee for providing your protected health information in that format. If you prefer, we will prepare a summary or an explanation of your protected health information, but we might charge a fee to do so.

We might deny your request to inspect and copy your protected health information in certain limited circumstances. Under certain conditions, our denial will not be reviewable. If this event occurs, we will inform you in our denial that the decision is not reviewable. If you are denied access to your information and the denial is subject to review, you may request that the denial be reviewed, where required by HIPAA. A licensed health care

professional chosen by us will review your request and the denial. The person performing this review will not be the same person who denied your initial request.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your protected health information for purposes other than treatment, payment, health care operations and certain other activities, after April 14, 2003. We will provide you with the date on which we made the disclosure, the name of the person or entity to which we disclosed your protected health information, a description of the protected health information we disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, we might charge you a reasonable, cost-based fee for responding to these additional requests.

You may request an accounting by submitting your request in writing using the information listed at the end of this notice. Your request may be for disclosures made up to 6 years before the date of your request, but in no event, for disclosures made before April 14, 2003.

Restriction Requests: You have the right to request that we place additional restrictions on our use or disclosure of your protected health information. Except as otherwise required by law, we will comply with your request to restrict disclosure to a health plan for purposes of carrying out payment or health care operations (but not for purposes of carrying out treatment) if the protected health information pertains solely to a health care item or service for which you or another person has paid in full. We are not required to agree to additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement that we might make to a request for additional restrictions must be in writing and signed by a person authorized to make such an agreement on our behalf. We will not be liable for uses and disclosures made outside of the requested restriction unless our agreement to restrict is in writing. We are permitted to end our agreement to the requested restriction by notifying you in writing.

You may request a restriction by writing to us using the information listed at the end of this notice. In your request tell us: (1) the information of which you want to limit our use and disclosure; and (2) how you want to limit our use and/or disclosure of the information.

Confidential Communication: If you believe that a disclosure of all or part of your protected health information may endanger you, you have the right to request that we communicate with you in confidence about your protected health information. This means that you may request that we send you information by alternative means, or to an alternate location. We must accommodate your request if: it is reasonable and practicable, specifies the alternative means or alternate location, and specifies how payment issues will be handled. You may request a Confidential Communication by writing to us using the information listed at the end of this notice.

Amendment: You have the right to request that we amend your protected health information. Your request must be

in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

Electronic Notice: Even if you agree to receive this notice on our web site, or by electronic mail (e-mail), you are entitled to receive a paper copy as well. Please contact us using the information listed at the end of this notice to obtain this notice in written form. If the e-mail transmission has failed, and the Company is aware of the failure, then we will provide a paper copy of the notice to you.

Right to be Notified of a Breach: You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured protected health information involving your protected health information.

Questions and Complaints

Information on the Company's Privacy Practices. If you want more information about our privacy practices or have questions or concerns about exercising your individual rights as described on page 4 of this notice, please contact the Company or one of the health plan representatives listed on this page.

Filing a Complaint: If you are concerned that we might have violated your privacy rights, or if you disagree with a decision we made about your individual rights, you may use the contact information listed at the end of this Notice to complain to us. You also may submit a written complaint to the U.S. Department of Health and Human Services (DHHS). We will provide you with the contact information for DHHS upon request.

We support your right to protect the privacy of your protected health and financial information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Washington Gas Light Company Contact Information

Contact Office:

Washington Gas Light Company
Human Resources Department
6801 Industrial Road
Springfield, VA 22151
703-750-7558

Contact Information for Plan Representatives

CareFirst PPO Plan: CareFirst
(1-800-628-8549)

CareFirst CDHP Plan: CareFirst
(1-800-628-8549)

Prescription Drug Plan: Caremark
(1-800-966-5772)

Dental Care Plan: Delta Dental
(1-800-237-6060)

Health FSA: WageWorks
(1-877-924-3967)

EAP: (1-800-634-6433 (password – WGL1))

Special Rights on Childbirth

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother of newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Important Notice from Washington Gas Light Company About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Washington Gas Light Company and its participating affiliates ("Washington Gas") and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Washington Gas has determined that the prescription drug coverage offered by the Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current CareFirst PPO Medical Plan, CareFirst Consumer Directed Health Plan coverage or CareFirst PPO Retiree Medical Plan will be affected. These plans pay for other health expenses in addition to prescription drug coverage. If you join a Medicare drug plan, you and your dependents will not

continue to be eligible to receive all of the current prescription drug benefits under the CareFirst PPO Medical Plan, the CareFirst Consumer Directed Health Plan or the CareFirst PPO Retiree Medical Plan. For further information on how your coverage will be affected, please review the Summary Plan Description or contact Washington Gas HR Services at 703-750-7779.

If you do decide to join a Medicare drug plan and drop your current Washington Gas coverage, be aware that you and your dependents will not be able to reinstate your coverage under the Washington Gas plan.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Washington Gas and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Washington Gas changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	1/1/2020
Name of Entity / Sender:	Washington Gas Light Company
Contact--Position/Office:	Washington Gas HR Services
Address:	6801 Industrial Road, Springfield, VA 22151
Phone Number:	703-750-7779