

UnitedHealthcare Choice

UnitedHealthcare of the Mid-Atlantic, Inc.

Certificate of Coverage

For

the Plan BVOA

of

AIMS Benefit Trust

Group Number: 717578

Effective Date: January 1, 2022

UnitedHealthcare of the Mid-Atlantic, Inc.

185 Asylum Street

Hartford, Connecticut 06103-3408

UNITEDHEALTHCARE INSURANCE COMPANY

A handwritten signature in black ink, appearing to read 'Joe Ochipinti', written over a horizontal line.

Joseph A. Ochipinti, President and CEO

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UnitedHealthcare Choice

UnitedHealthcare of the Mid-Atlantic, Inc.

Schedule of Benefits

How Do You Access Benefits?

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this *Schedule of Benefits*, Benefits are not available for services provided by out-of-Network providers. This Benefit plan does not provide an out-of-Network level of Benefits, however, Benefits are provided when Covered Health Care Services are received from an out-of-Network provider as a result of an Emergency, at an Urgent Care Center outside your geographic area, or if a Covered Health Care Service received by an out-of-Network provider was preauthorized or otherwise approved by us or a Network provider, or obtained pursuant to a verbal or written referral by us or a Network provider.

Benefits apply to Covered Health Care Services that are provided by a Network Physician or other Network provider. You are not required to select a Primary Care Physician in order to obtain Benefits.

Benefits for facility services apply when Covered Health Care Services are provided at a Network facility. Benefits include Physician services provided in a Network facility by a Network or an out-of-Network radiologist, anesthesiologist, pathologist, Emergency room Physician and consulting Physician. Emergency Health Care Services, Covered Health Care Services received for an unforeseen illness, injury or condition requiring immediate medical care, and Covered Health Care Services received at an Urgent Care Center outside your geographic area are always paid as Network Benefits even if received from an out-of-Network provider.

Depending on the geographic area and the service you receive, you may have access through our Shared Savings Program to out-of-Network providers who have agreed to discount their billed charges for Covered Health Care Services. Refer to the definition of Shared Savings Program in *Section 9: Defined Terms* of the *Certificate* for details about how the Shared Savings Program applies.

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under a UnitedHealthcare of the Mid-Atlantic, Inc. Policy. and the provider may fail to bill the correct entity for the services delivered, and any resulting delay may mean that you will be unable to collect any Benefits otherwise owed to you. If you forget your ID card, it may cause a delay in obtaining Benefits, but does not eliminate the ability to obtain Benefits.

Additional information about the network of providers and how your Benefits may be affected appears at the end of this *Schedule of Benefits*.

If there is a conflict between this *Schedule of Benefits* and any summaries provided to you by the Group, this *Schedule of Benefits* will control.

Does Prior Authorization Apply?

Network providers are responsible for obtaining prior authorization for certain Covered Health Care Services before they provide these services to you.

Before receiving Covered Health Care Services from a Network provider, you may want to call us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the

required prior authorization. Network facilities and Network providers cannot bill you for services they do not prior authorize as required. You can call us at the telephone number on your ID card.

Utilization Review Determinations

For any Benefit for which utilization review applies, the following will apply.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include, but are not limited to, ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review.

We do not make treatment decisions about the kind of care you should or should not receive. You and your provider must make those treatment decisions.

A private review agent will make all utilization review decisions. Providers are promptly notified of all utilization review decisions. A private review agent will be available 24 hours a day, 7 days a week.

Initial utilization review Benefit determinations on whether to authorize or certify a non-Emergency course of treatment will be made within two (2) working days after receipt of information necessary to make the determination.

Utilization review determinations to authorize or certify an extended stay in a health care facility or to provide additional health care service will be made within one (1) working day after receipt of necessary information.

If within three (3) days after the receipt of the initial request, additional information is required to make a determination, your provider will be notified that additional information is required.

When prior authorization is required for inpatient or Residential Crisis Services for the treatment of Mental Health Care and Substance-Related and Addictive Disorders Services, determinations on whether or not to authorize or certify such services will be made within 2 hours after receipt of necessary information.

Prior authorization is not required for Emergency Health Care Services.

If the initial determination is not to authorize or certify services and the provider believes the decision warrants reconsideration, the provider will be provided the opportunity to speak with the Physician who rendered the decision. Such discussion will take place by telephone within 24 hours on an expedited basis of the request for reconsideration.

Adverse decisions for emergency inpatient admissions may not be made solely because the Hospital did not notify within 24 hours of admission or other time period after admission because the patient's medical condition prohibited determination of: 1) the patient insurance status; and 2) any applicable admission notification requirements.

An adverse determination may not be rendered during the first 24 hours after admission if; a) the admission is based on the patient as an imminent danger to self or others; b) the determination is made by the patient's Physician or psychologist in conjunction with a member of the medical facility who has privileges to make the admission; and c) the Hospital immediately provides notification of the admission and the reasons for admission.

An adverse determination may not be rendered for admission to a Hospital for up to 72 hours, as determined to be Medically Necessary by the patient's treating physician when; a) the admission is an involuntary admission as described under Health General Articles §10-615 and §10-617(a) and; b) the Hospital immediately provides notification of the admission and the reasons for admission.

If the provider is required to submit a treatment plan in order for utilization review to be conducted for Mental Health Care and Substance-Related and Addictive Disorders Services, the uniform treatment plan as provided under Maryland insurance law will be accepted or, if service was provided in another state, a

treatment plan mandated by that state. Such treatment plan must be properly completed by the provider and may be submitted by electronic transfer.

Your Right to a Second Opinion about Hospital Utilization Review Decisions

The State of Maryland requires all acute general Hospitals to maintain a stringent utilization review process. This means that certain items such as elective inpatient hospital admissions, certain inpatient surgical procedures and length of inpatient stay may be subject to review or prior-authorization by the hospital in addition to any such review or prior-authorization requirement under the terms of this Policy.

If the hospital's utilization review results in denial of inpatient services, we will pay the cost of a corresponding outpatient service. If the hospital's utilization review requires a second opinion, we will cover all reasonable expenses in connection with the second opinion in full with no Co-payment, Co-insurance, or deductible.

What Will You Pay for Covered Health Care Services?

Benefits for Covered Health Care Services are described in the tables below.

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Limits are calculated on a calendar year basis.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term And Description	Amounts
Annual Deductible	
<p>The amount you incur for Covered Health Care Services per year before you are eligible to receive Benefits.</p> <p>Coupons: We may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible. You may access information on which coupons or offers are not permitted by contacting us at www.myuhc.com or the telephone number on your ID card.</p> <p>Amounts paid toward the Annual Deductible for Covered Health Care Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible.</p> <p>When a Covered Person was previously covered under a group policy that was replaced by the group Policy, any amount already applied to that annual deductible provision of the prior policy will apply to the Annual Deductible provision under the Policy.</p> <p>The amount that is applied to the Annual Deductible is calculated on the basis of the Allowed Amount. The Annual Deductible does not include any amount that exceeds the Allowed Amount. Details about the way in which Allowed Amounts are determined appear at the end of the <i>Schedule of Benefits</i> table.</p>	<p>\$2,000 per Covered Person, not to exceed \$4,000 for all Covered Persons in a family.</p>

Payment Term And Description	Amounts
The Annual Deductible does not include any applicable Per Occurrence Deductible.	
Per Occurrence Deductible	
<p>The amount stated as a set dollar amount that you incur for certain Covered Health Care Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Care Services.</p> <p>You are responsible for paying the lesser of the following:</p> <ul style="list-style-type: none"> • The applicable Per Occurrence Deductible. • The Allowed Amount. 	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Care Service category.
Out-of-Pocket Limit	
<p>The maximum you incur per year for the Annual Deductible, the Per Occurrence Deductible, Co-payments or Co-insurance. These are considered out-of-pocket expenses. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year. The Out-of-Pocket Limit applies to Covered Health Care Services under the Policy as indicated in this <i>Schedule of Benefits</i>, including Covered Health Care Services provided under the <i>Outpatient Prescription Drug Rider</i>.</p> <p>Details about the way in which Allowed Amounts are determined appear at the end of the <i>Schedule of Benefits</i> table.</p> <p>The Out-of-Pocket Limit does not include any of the following and, once the Out-of-Pocket Limit has been reached, you still will be required to pay the following:</p> <ul style="list-style-type: none"> • Any charges for non-Covered Health Care Services. • Charges that exceed Allowed Amounts. <p>Coupons: We may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Out-of-Pocket Limit. You may access information on which coupons or offers are not permitted by contacting us at www.myuhc.com or the telephone number on your ID card.</p>	\$7,350 per Covered Person, not to exceed \$14,700 for all Covered Persons in a family.
Co-payment	
Co-payment is the amount you incur (calculated as a set dollar amount) each time you receive certain Covered Health Care Services. When Co-payments apply, the amount is listed on the following pages next to the description for each Covered Health Care Service. Any dollar amount Co-payment is paid directly to the provider of the Covered Health Care Service at the time of service. If the provider does not ask for payment of the Co-payment at the time service is rendered or a supply provided, you need not pay the Co-payment at that time, and the provider will bill you for the Co-payment. You will never be denied Covered Health Care Services because of an inability to meet the Co-payment requirement.	

Payment Term And Description	Amounts
<p>Please note that for Covered Health Care Services, you are responsible for paying the lesser of:</p> <ul style="list-style-type: none"> • The applicable Co-payment. • The Allowed Amount. <p>Details about the way in which Allowed Amounts are determined appear at the end of the <i>Schedule of Benefits</i> table.</p>	
<p>Co-insurance</p>	
<p>Co-insurance is the amount you incur (calculated as a percentage of the Allowed Amount) each time you receive certain Covered Health Care Services.</p> <p>Details about the way in which Allowed Amounts are determined appear at the end of the <i>Schedule of Benefits</i> table.</p>	

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
1. Acupuncture Services			
Limited to 10 treatments per year.	None	No	No
2. Ambulance Services			
In most cases, we will initiate and direct non-Emergency ambulance transportation.			
Emergency Ambulance Non-Emergency Ambulance Ground or air ambulance, as we determine appropriate.	<i>Ground Ambulance</i> 20% <i>Air Ambulance</i> 20% <i>Ground Ambulance</i> 20% <i>Air Ambulance</i> 20%	Yes Yes Yes Yes	Yes Yes Yes Yes
3. Cellular and Gene Therapy			
Cellular or Gene Therapy services must be received from a Designated Provider.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> .		
4. Clinical Trials			
Depending upon the Covered Health Care Service, Benefit limits are the same as those stated under the specific Benefit category in this <i>Schedule of Benefits</i> .	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> .		
5. Congenital Heart Disease (CHD)			

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
Surgeries			
<p>It is important that your provider notify us regarding your intention to have surgery. This notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.</p>			
Benefits under this section include only the inpatient facility charges for the CHD surgery. Depending upon where the Covered Health Care Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> .	20%	Yes	Yes
6. Dental Services - Accident Only			
	20%	Yes	Yes
7. Diabetes Services			
<p>Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care</p> <p>Diabetes Self-Management Items</p>	<p>Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management and training/diabetic eye exams/foot care will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>, except that any limit on the amount or duration of Benefits specific to such Covered Health Care Service category does not apply to Benefits for diabetes self-management items under this Covered Health Care Service.</p> <p>Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under <i>Durable Medical Equipment (DME), Orthotics and Supplies</i> and in the <i>Outpatient Prescription Drug Rider</i> except that any limit on the amount or duration of Benefits specific to the Durable Medical Equipment Benefit category or the <i>Outpatient Prescription Drug Rider</i> does not apply to Benefits for diabetes self-management items under this Covered Health Care Service. Diabetes test strips are not subject to Co-insurance or Co-payment.</p>		

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
8. Durable Medical Equipment (DME), Orthotics and Supplies			
<p>Benefits are limited to a single purchase of a type of DME or orthotic every three years. Repair and/or replacement of DME or orthotics would apply to this limit in the same manner as a purchase. This limit does not apply to wound vacuums, which are limited to a single purchase (including repair/replacement) every three years.</p> <p>Note: Treatment for lymphedema received in connection with the <i>Lymphedema Services</i> Benefit shown below under <i>Additional Benefits Required by Maryland Law</i>, are not subject to any limit shown above.</p> <p>You must purchase, rent, or obtain the DME or orthotic from the vendor we identify or purchase it directly from the prescribing Network Physician.</p>	20%	Yes	Yes
9. Emergency Health Care Services - Outpatient			
<p>Note: If you are admitted, being observed or otherwise receiving treatment in an out-of-Network Hospital after you receive outpatient Emergency Health Care Services, you must notify us within one business day or on the same day of admission if reasonably possible. We may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the out-of-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided.</p>	20%	Yes	Yes, after the Per Occurrence Deductible of \$250 per visit is satisfied

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?						
If you are admitted as an inpatient to a Hospital directly from the Emergency room, the Benefits provided as described under Hospital - Inpatient Stay will apply. You will not have to pay the Emergency Health Care Services Co-payment, Co-insurance and/or deductible.									
10. Gender Dysphoria									
<p align="center">It is important that your provider notify us as soon as the possibility of surgery arises.</p> <p align="center">This notification allows the opportunity for us to provide you with additional information and services that may be available to you and are designed to achieve the best outcomes for you.</p>									
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> and in the <i>Outpatient Prescription Drug Rider</i> .								
11. Habilitative Services									
	<p><i>Inpatient</i></p> <p>Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> except that any limit on the amount or duration of Benefits specific to such Covered Health Care Service category does not apply to Benefits under this Covered Health Care Service.</p> <table border="1" data-bbox="651 1457 1414 1612"> <tr> <td data-bbox="651 1457 938 1612"><i>Outpatient</i></td> <td data-bbox="938 1457 1179 1612"></td> <td data-bbox="1179 1457 1414 1612"></td> </tr> <tr> <td data-bbox="651 1507 938 1612">20%</td> <td data-bbox="938 1507 1179 1612">Yes</td> <td data-bbox="1179 1507 1414 1612">Yes</td> </tr> </table>			<i>Outpatient</i>			20%	Yes	Yes
<i>Outpatient</i>									
20%	Yes	Yes							
12. Hearing Aids									
Benefits for all Covered Persons are limited to a single purchase per hearing impaired ear every three years. Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.	20%	Yes	Yes						

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on **Allowed Amounts**. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
13. Home Health Care			
<p>Limited to 200 visits per year. One visit equals up to four hours of skilled care services.</p> <p>This visit limit does not include any service which is billed only for the administration of intravenous infusion.</p> <p>For the administration of intravenous infusion, you must receive services from a provider we identify.</p> <p>Co-payment/Co-insurance and deductible will not apply to postpartum home visits, as described in the Certificate under <i>Home Health Care</i> in <i>Section 1: Covered Health Care Services</i>.</p>	20%	Yes	Yes
14. Hospice Care			
	20%	Yes	Yes
15. Hospital - Inpatient Stay			
	20%	Yes	Yes
16. Infertility Services			
<p>NOTE: Infertility Services does not include in vitro fertilization. See below under <i>Additional Benefits Required by Maryland Law</i> for a description of the in vitro fertilization Benefits available to you.</p>	20%	Yes	Yes
17. Lab, X-Ray and Diagnostic - Outpatient			

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
Lab Testing - Outpatient	20%	Yes	Yes
X-Ray and Other Diagnostic Testing - Outpatient	20%	Yes	Yes
18. Major Diagnostic and Imaging - Outpatient			
	20%	Yes	Yes
19. Mental Health Care and Substance-Related and Addictive Disorders Services			
	<i>Inpatient</i> 20%	Yes	Yes
	<i>Outpatient</i> None	No	No
	20% for Partial Hospitalization/Intensive Outpatient Treatment and all other outpatient services except office visits	Yes	Yes
20. Ostomy and Urologic Supplies			
	20%	Yes	Yes

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
21. Pharmaceutical Products - Outpatient			
The Co-payment or Co-insurance for a Pharmaceutical Product will never exceed the retail price of the Pharmaceutical Product.	20% For Specialty Prescription Drug Pharmaceutical Products, you will never pay more than \$150 per 30-day supply. This includes those outpatient injectable drugs that meet the criteria for a Specialty Drug. For Pharmaceutical Products to treat diabetes, HIV or AIDS, you will never pay more than \$150 per 30-day supply.	Yes	Yes
22. Physician Fees for Surgical and Medical Services			
	20%	Yes	Yes
23. Physician's Office Services - Sickness and Injury			
	None per visit for a Primary Care Physician office visit or \$60 per visit for a Specialist office visit	Yes	No
24. Pregnancy - Maternity Services			
It is important that your provider notify us regarding your Pregnancy. This notification will open			

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
<p>the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.</p>			
<p>Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.</p>			
<p>25. Preventive Care Services</p>			
Physician office services	None	No	No
Lab, X-ray or other preventive tests	None	No	No
Breast pumps	None	No	No
<p>26. Prosthetic Devices</p>			
<p>Benefits are limited to a single purchase of each type of prosthetic device every three years. Repair and/or replacement of a prosthetic device would apply to this limit in the same manner as a purchase.</p> <p>Once this limit is reached, Benefits continue to be available for items required by the <i>Women's Health and Cancer Rights Act of 1998</i>.</p>	20%	Yes	Yes
<p>27. Reconstructive Procedures</p>			
<p>Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>, except that any limit on the amount or duration of Benefits specific to such Covered Health Care Service category does not apply to Benefits for reconstructive breast surgery under this Covered Health Care Service.</p>			
<p>28. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment</p>			

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
Limited per year as follows: <ul style="list-style-type: none"> • 60 visits of physical therapy. • 60 visits of occupational therapy. • 60 Manipulative Treatments. • 60 visits of speech therapy. • 60 visits of pulmonary rehabilitation therapy. • 36 visits of cardiac rehabilitation therapy. • 30 visits of post-cochlear implant aural therapy. • 20 visits of cognitive rehabilitation therapy. 	Network 20%	Yes	Yes
29. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	20%	Yes	Yes
30. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to 180 days per year.	20%	Yes	Yes
31. Surgery - Outpatient			
Co-payment/Co-insurance and deductible will not apply to male sterilization, as described in the Certificate under <i>Surgery - Outpatient</i> in <i>Section 1: Covered Health Care</i>	20%	Yes	Yes

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
<i>Services.</i>			
32. Therapeutic Treatments - Outpatient			
	20%	Yes	Yes
33. Transplantation Services			
Transplantation services must be received from a Designated Provider. We do not require that cornea transplants be received from a Designated Provider.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> .		
34. Urgent Care Center Services			
<p>Co-payment/Co-insurance and any deductible for the following services also apply when the Covered Health Care Service is performed at an Urgent Care Center:</p> <ul style="list-style-type: none"> • Major diagnostic and nuclear medicine described under <i>Major Diagnostic and Imaging - Outpatient</i>. • Outpatient Pharmaceutical Products described under <i>Pharmaceutical Products - Outpatient</i>. • Diagnostic and therapeutic scopic procedures described under <i>Scopic Procedures - Outpatient Diagnostic and Therapeutic</i>. • Outpatient surgery procedures described under <i>Surgery - Outpatient</i>. • Outpatient therapeutic 	\$50 per visit	Yes	No

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
procedures described under <i>Therapeutic Treatments - Outpatient</i> .			
35. Urinary Catheters			
	20%	Yes	Yes
36. Virtual Visits			
Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting us at www.myuhc.com or the telephone number on your ID card.	None	No	No
37. Wigs			
Limited to \$350 per year.	20%	Yes	Yes
Additional Benefits Required By Maryland Law			
38. Amino Acid-Based Elemental Formula			
	20%	Yes	Yes
39. Bones of Face, Neck and Head			
	20%	Yes	Yes
40. Child Wellness Services			
	None	No	No

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
41. Treatment of Cleft Lip or Palate or Both			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> except that any limit on the amount or duration of Benefits specific to such Covered Health Care Service category does not apply to Benefits under this Covered Health Care Service.		
42. Dental Services - Hospital and Alternate Facility Health Services Related to Dental Care			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> except that any limit on the amount or duration of Benefits specific to such Covered Health Care Service category does not apply to Benefits under this Covered Health Care Service.		
43. Hair Prosthesis			
Limited to \$350 per year.	20%	Yes	Yes
44. In Vitro Fertilization			
Limited to three in vitro fertilization attempts per live birth, subject to a maximum Benefit of \$100,000 per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy. This limit includes Benefits for medications associated with in vitro fertilization, as provided under the <i>Outpatient Prescription Drug Rider</i> .	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> except that any limit on the amount or duration of Benefits specific to such Covered Health Care Service category does not apply to Benefits under this Covered Health Care Service.		
45. Lymphedema Services			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule</i>		

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
	<i>of Benefits</i> except that any limit on the amount or duration of Benefits specific to such Covered Health Care Service category does not apply to Benefits under this Covered Health Care Service.		
46. Medical Foods			
	20%	Yes	Yes
47. Standard Fertility Preservation Procedures			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> except that any limit on the amount or duration of Benefits specific to such Covered Health Care Service category does not apply to Benefits under this Covered Health Care Service.		
48. Surgical Morbid Obesity Treatment			
It is important that your provider notify us regarding your intention to have surgery. This notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> .		
49. Telemedicine Services			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> except that any limit on the amount or duration of Benefits specific to such Covered Health Care Service category does not apply to Benefits under this Covered Health Care Service.		

Allowed Amounts

Allowed Amounts are the amount we determine that we will pay for Benefits. For Network Benefits, except for your cost sharing obligations, you are not responsible for any difference between Allowed Amounts and the amount the provider bills. Allowed Amounts are determined solely in accordance with our reimbursement policy guidelines, as described in the *Certificate*.

For Network Benefits, Allowed Amounts are based on the following:

- When Covered Health Care Services are received from a Network provider, Allowed Amounts are our contracted fee(s) with that provider.
- When Covered Health Care Services are received from an out-of-Network provider as a result of an Emergency, at an Urgent Care Center outside your geographic area or if a Covered Health Care Service received by an out-of-network provider was preauthorized or otherwise approved by us or a Network provider, or obtained pursuant to a verbal or written referral by us or a Network provider, the applicable payment for Allowed Amounts is set forth under *Section 19-710.1 of the Maryland Health General Article*. When Covered Health Care Services are received from an out-of-Network provider as a result of an Emergency, the Co-payment and Co-insurance will be the same as if the Covered Health Care Services were received from a Network Provider.

Allowed Amounts for a Covered Health Care Service provided by an out-of-Network ambulance service provider may not be less than the Allowed Amount paid to a Network ambulance service provider for the same Covered Health Care Service in the same geographic region, as defined by the *Centers for Medicare and Medicaid Services*.

We will pay hospitals for hospital services rendered on the basis of the rate approved by the Health Services Cost Review Commission and comply with the applicable terms and conditions of Maryland's all-payer model contract approved by the federal *Center for Medicare and Medicaid Innovation*.

Provider Network

We arrange for health care providers to take part in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to choose your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling the telephone number on your ID card. A directory of providers is available by contacting us at www.myuhc.com or the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Benefits.

If you are currently undergoing a course of treatment using an out-of-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help to find out if you are eligible for transition of care Benefits, please call the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Care Services. Some Network providers contract with us to provide only certain Covered Health Care Services, but not all Covered Health Care Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for help.

Designated Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Provider chosen by us. If you require certain complex Covered Health Care Services for which expertise is limited and there are no providers in your local geographic area that can provide the services, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Care Services from a Designated Provider, we may reimburse certain travel expenses.

In both cases, Benefits will only be paid if your Covered Health Care Services for that condition are provided by or arranged by the Designated Provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants or cancer treatment) that might warrant referral to a Designated Provider. If you do not coordinate care through your Network Physician, and if you receive services from an out-of-Network facility (regardless of whether it is a Designated Provider) or other out-of-Network provider, without a verbal or written referral or other approval or authorization by us or a Network Provider, Benefits will not be paid.

If there is not a Designated Facility, Designated Physician or other Network facility or provider available, you may be eligible for services provided from an out-of-Network provider as described below under *Health Services from Out-of-Network Providers*.

If there is not a Designated Facility, Designated Physician or other Network facility or provider available and the services you received are Emergency Health Care Services, Covered Health Care Services received for an unforeseen illness, injury or condition requiring immediate care or Covered Health Care Services received at an Urgent Care Center outside your geographic area, Benefits will be paid as Network Benefits, even if received from an out-of-Network provider.

Health Care Services from Out-of-Network Providers

If you are diagnosed with a condition or disease that requires specialized health care services or medical care and such specialized service or care is either not available from a Network provider or access to such a Network provider would require unreasonable delay or travel, you may be eligible for Network Benefits when Covered Health Care Services are received from out-of-Network providers.

In this situation, you may request a referral to an out-of-Network provider from your Network Physician who will notify us and, if we confirm that the required specialized service or care is not available from a Network provider without unreasonable delay or travel, we will work with you and your Network Physician to coordinate care through an out-of-Network provider. When coordinated, such service received from an out-of-Network provider will be treated as Network Benefits, including any applicable Co-payment, Co-insurance and deductible requirements.

Limitations on Selection of Providers

If we determine that you are using health care services in a harmful or abusive manner, or with harmful frequency, your selection of Network providers may be limited. If this happens, we may require you to select a single Network Physician to provide and coordinate all future Covered Health Care Services.

If you don't make a selection within 31 days of the date we notify you, we will select a single Network Physician for you.

If you do not use the selected Network Physician, Benefits will not be paid. However, this does not apply to situations regarding specialized care services for which Benefits may be provided as described above under *Health Service Provided by Out-of-Network Providers*. *Emergency Health Care Services*, Covered Health Care Services received for an unforeseen illness, injury or condition requiring immediate medical care, and Covered Health Care Services received at an Urgent Care Center outside your geographic area are always paid as Network Benefits.

Continuity of Care

At your request or the request of your parent, guardian, designee, or health care provider, we will accept prior authorization from your prior coverage carrier upon your transition to coverage under this Policy for:

- The procedures, treatments, medications or services that are Covered Health Care Services under this Policy for the following periods of time:
 - The lesser of the course of treatment or 90 days; and
 - The duration of the three trimesters of a Pregnancy and the initial postpartum visit.

Upon transition from your prior carrier coverage to this Policy, we will allow you to continue prior carrier health care services when they are Covered Health Care Services under this Policy provided by an out-of-Network provider for the following conditions:

- Acute conditions;
- Serious chronic conditions;
- Pregnancy;
- Mental Health Care and Substance-Related and Addictive Disorders Services; and
- Any other condition for which the out-of-Network provider and us reach agreement.

A Covered Person will be allowed to continue to receive the services for the conditions list above for the following time periods:

- The lesser of the course of treatment or 90 days; and
- The duration of the three trimesters of a Pregnancy and the initial postpartum visit.

We will pay an out-of-Network provider under this provision in accordance with all the applicable requirements of rates and methods of payment under Maryland and federal law.

Certificate of Coverage

UnitedHealthcare of the Mid-Atlantic, Inc.

What Is the Certificate of Coverage?

This *Certificate of Coverage (Certificate)* is part of the Policy that is a legal document between UnitedHealthcare of the Mid-Atlantic, Inc. and the Group. The *Certificate* describes Covered Health Care Services, subject to the terms, conditions, exclusions and limitations of the Policy. We issue the Policy based on the Group's *Application* and payment of the required Policy Charges.

In addition to this *Certificate*, the Policy includes:

- The *Schedule of Benefits*.
- The Group's *Application*.
- Riders, including the *Outpatient Prescription Drug Rider*.
- Amendments.

You can review the Policy at the Group's office during regular business hours.

Can This Certificate Change?

We may, from time to time, change this *Certificate* by attaching legal documents called Riders and/or Amendments that may change certain provisions of this *Certificate*. When this happens we will send you a new *Certificate*, Rider or Amendment.

No one can make any changes to the Policy unless those changes are in writing, approved by an executive officer and included in or attached to the contract.

Other Information You Should Have

We have the right to change, interpret, withdraw or add Benefits, or to end the Policy, as permitted by law, without your approval.

On its effective date, this *Certificate* replaces and overrules any *Certificate* that we may have previously issued to you. This *Certificate* will in turn be overruled by any *Certificate* we issue to you in the future.

The Policy will take effect on the date shown in the Policy. Coverage under the Policy starts at 12:01 a.m. and ends at 12:00 midnight in the time zone of the Group's location. The Policy will remain in effect as long as the Policy Charges are paid when they are due, subject to *Section 4: When Coverage Ends*.

We are delivering the Policy in Maryland. The Policy is subject to the laws of the state of Maryland and ERISA, unless the Group is not a private plan sponsor subject to ERISA. To the extent that state law applies, Maryland law governs the Policy.

Introduction to Your Certificate

This *Certificate* and the other Policy documents describe your Benefits, as well as your rights and responsibilities, under the Policy.

What Are Defined Terms?

Certain capitalized words have special meanings. We have defined these words in *Section 9: Defined Terms*.

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare of the Mid-Atlantic, Inc. When we use the words "you" and "your," we are referring to people who are Covered Persons, as that term is defined in *Section 9: Defined Terms*.

How Do You Use This Document?

Read your entire *Certificate* and any attached Riders and/or Amendments. You may not have all of the information you need by reading just one section. Keep your *Certificate* and *Schedule of Benefits* and any attachments in a safe place for your future reference. You can also get this *Certificate* at www.myuhc.com.

Review the Benefit limitations of this *Certificate* by reading the attached *Schedule of Benefits* along with *Section 1: Covered Health Care Services* and *Section 2: Exclusions and Limitations*. Read *Section 8: General Legal Provisions* to understand how this *Certificate* and your Benefits work. Call us if you have questions about the limits of the coverage available to you.

If there is a conflict between this *Certificate* and any summaries provided to you by the Group, this *Certificate* controls.

Please be aware that your Physician is not responsible for knowing or communicating your Benefits.

How Do You Contact Us?

Call the telephone number listed on your identification (ID) card. Throughout the document you will find statements that encourage you to contact us for more information.

Your Responsibilities

Enrollment and Required Contributions

Benefits are available to you if you are enrolled for coverage under the Policy. Your enrollment options, and the corresponding dates that coverage begins, are listed in *Section 3: When Coverage Begins*. To be enrolled and receive Benefits, both of the following apply:

- Your enrollment must be in accordance with the requirements of the Policy issued to your Group, including the eligibility requirements.
- You must qualify as a Subscriber or a Dependent as those terms are defined in *Section 9: Defined Terms*.

Your Group may require you to make certain payments to them, in order for you to remain enrolled under the Policy. If you have questions about this, contact your Group.

Be Aware the Policy Does Not Pay for All Health Care Services

The Policy does not pay for all health care services. Benefits are limited to Covered Health Care Services. The *Schedule of Benefits* will tell you the portion you must pay for Covered Health Care Services.

Decide What Services You Should Receive

Care decisions are between you and your Physician. We do not make decisions about the kind of care you should or should not receive.

Choose Your Physician

It is your responsibility to select the health care professionals who will deliver your care. We arrange for Physicians and other health care professionals and facilities to participate in a Network. Our credentialing process confirms public information about the professionals' and facilities' licenses and other credentials, but does not assure the quality of their services. These professionals and facilities are independent practitioners and entities that are solely responsible for the care they deliver.

Obtain Prior Authorization

Some Covered Health Care Services require prior authorization. Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization.

Pay Your Share

You must meet any applicable deductible and pay a Co-payment and/or Co-insurance for most Covered Health Care Services. These payments are due at the time of service or when billed by the Physician, provider or facility. Any applicable deductible, Co-payment and Co-insurance amounts are listed in the *Schedule of Benefits*.

Pay the Cost of Excluded Services

You must pay the cost of all excluded services and items. Review *Section 2: Exclusions and Limitations* to become familiar with the Policy's exclusions.

Show Your ID Card

You should show your ID card every time you request health care services. If you do not show your ID card, the provider may fail to bill the correct entity for the services delivered.

File Claims with Complete and Accurate Information

When you receive Covered Health Care Services from an out-of-Network provider as a result of an Emergency, at an Urgent Care Center outside the Service Area, or if a Covered Health Care Service received by an out-of-Network provider was preauthorized or otherwise approved by us or a Network provider, or obtained pursuant to a verbal or written referral by us or a Network provider, we pay out-of-Network providers directly. However, if you have already paid the out-of-Network provider, we will accept a request for payment submitted by you. If you submit a request for payment, you must file the claim in a format that contains all of the information we require, as described in *Section 5: How to File a Claim*.

Our Responsibilities

Determine Benefits

We make administrative decisions regarding whether the Policy will pay for any portion of the cost of a health care service you intend to receive or have received. Our decisions are for payment purposes only. We do not make decisions about the kind of care you should or should not receive. You and your providers must make those treatment decisions.

We have the final authority to do the following:

- Interpret Benefits and the other terms, limitations and exclusions set out in this *Certificate*, the *Schedule of Benefits* and any Riders and/or Amendments.
- Make factual determinations relating to Benefits.

We may assign this authority to other persons or entities that may provide administrative services for the Policy, such as claims processing. The identity of the service providers and the nature of their services may be changed from time to time as we determine. In order to receive Benefits, you must cooperate with those service providers.

Pay for Our Portion of the Cost of Covered Health Care Services

We pay Benefits for Covered Health Care Services as described in *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*, unless the service is excluded in *Section 2: Exclusions and Limitations*. This means we only pay our portion of the cost of Covered Health Care Services. It also means that not all of the health care services you receive may be paid for (in full or in part) by the Policy.

Pay Network Providers

It is the responsibility of Network Physicians and facilities to file for payment from us. When you receive Covered Health Care Services from Network providers, you do not have to submit a claim to us.

Pay for Covered Health Care Services Provided by Out-of-Network Providers

When you receive Covered Health Care Services from an out-of-Network provider as a result of an Emergency, at an Urgent Care Center outside the Service Area, or if a Covered Health Care Service received by an out-of-Network provider was preauthorized or otherwise approved by us or a Network provider, or obtained pursuant to a verbal or written referral by us or a Network provider, we pay out-of-Network providers directly.

Review and Determine Benefits in Accordance with our Reimbursement Policies

See *Section 9: Defined Terms* for a description of our reimbursement policy guidelines.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), our reimbursement policies are applied to provider billings. We share our reimbursement policies with Physicians and other providers in our Network through our provider website. Physicians and providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. You may get copies of our reimbursement policies for yourself or to share with your provider by contacting us at www.myuhc.com or the telephone number on your ID card.

We may apply a reimbursement methodology established by *OptumInsight* and/or a third party vendor, which is based on *CMS* coding principles, to determine appropriate reimbursement levels for Emergency Health Care Services. The methodology is usually based on elements reflecting the patient complexity, direct costs, and indirect costs of an Emergency Health Care Service. If the methodology(ies) currently in use become no longer available, we will use a comparable methodology(ies). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at www.myuhc.com for information regarding the vendor that provides the applicable methodology.

Offer Health Education Services to You

We may provide you with access to information about additional services that are available to you, such as disease management programs, health education and patient advocacy. It is solely your decision whether to take part in the programs, but we recommend that you discuss them with your Physician.

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Section 1: Covered Health Care Services

When Are Benefits Available for Covered Health Care Services?

Benefits are available only when all of the following are true:

- The health care service, including supplies or Pharmaceutical Products, is only a Covered Health Care Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Care Service in *Section 9: Defined Terms*.)
- You receive Covered Health Care Services while the Policy is in effect or are provided to you under the *Extension of Coverage* in *Section 4: When Coverage Ends*.
- You receive Covered Health Care Services prior to the date that any of the individual termination conditions listed in *Section 4: When Coverage Ends* occurs or are provided to you under the *Extension of Coverage* in *Section 4: When Coverage Ends*.
- The person who receives Covered Health Care Services is a Covered Person and meets all eligibility requirements specified in the Policy or is receiving Benefits under the *Extension of Coverage* in *Section 4: When Coverage Ends*.

The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Care Service under the Policy.

This section describes Covered Health Care Services for which Benefits are available. Please refer to the attached *Schedule of Benefits* for details about:

- The amount you must pay for these Covered Health Care Services (including any Annual Deductible, Per Occurrence Deductible, Co-payment and/or Co-insurance).
- Any limit that applies to these Covered Health Care Services (including visit, day and dollar limits on services).
- Any limit that applies to the portion of the Allowed Amount you are required to pay in a year (Out-of-Pocket Limit).

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

1. Acupuncture Services

Acupuncture services provided in an office setting for the following conditions:

- Pain therapy.
- Nausea that is related to surgery, Pregnancy or chemotherapy.

Benefits are provided regardless of whether the office is free-standing, located in a clinic or located in a Hospital.

Acupuncture services must be performed by a provider who is either:

- Practicing within the scope of his/her license under the *Maryland Health Occupations Article*; or
- Certified by a national accrediting body.

2. Ambulance Services

Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance) to the nearest Hospital where the required Emergency Health Care Services can be performed.

Non-Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as we determine appropriate) between facilities only when the transport meets one of the following:

- From an out-of-Network Hospital to the closest Network Hospital when Covered Health Care Services are required.
- To the closest Network Hospital that provides the required Covered Health Care Services that were not available at the original Hospital.
- From a short-term acute care facility to the closest Network long-term acute care facility (LTAC), Network Inpatient Rehabilitation Facility, or other Network sub-acute facility where the required Covered Health Care Services can be delivered.

For the purpose of this Benefit the following terms have the following meanings:

- "Long-term acute care facility (LTAC)" means a facility or Hospital that provides care to people with complex medical needs requiring long-term Hospital stay in an acute or critical setting.
- "Short-term acute care facility" means a facility or Hospital that provides care to people with medical needs requiring short-term Hospital stay in an acute or critical setting such as for recovery following a surgery, care following sudden Sickness, Injury, or flare-up of a chronic Sickness.
- "Sub-acute facility" means a facility that provides intermediate care on short-term or long-term basis.

3. Cellular and Gene Therapy

Cellular Therapy and Gene Therapy received on an inpatient or outpatient basis at a Hospital or on an outpatient basis at an Alternate Facility or in a Physician's office.

Benefits for CAR-T therapy for malignancies are provided as described under *Transplantation Services*.

4. Clinical Trials

Routine patient care costs incurred while taking part in a qualifying clinical trial for the treatment of:

- Cancer or other life-threatening disease or condition. For purposes of this Benefit, a life-threatening disease or condition is one which is likely to cause death unless the course of the disease or condition is interrupted.
- Cardiovascular disease (cardiac/stroke) which is not life threatening, when we determine the clinical trial meets the qualifying clinical trial criteria stated below.
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, when we determine the clinical trial meets the qualifying clinical trial criteria stated below.
- Other diseases or disorders which are not life threatening, when we determine the clinical trial meets the qualifying clinical trial criteria stated below.

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from taking part in a qualifying clinical trial. Benefits also include coverage for costs incurred for drugs and devices that have been approved for sale by the *FDA*, whether or not the *FDA* has

approved the drug or device for use in treating your particular condition, provided that the drugs or devices are not paid for by the manufacturer, distributor or provider of that drug or device.

Benefits are available only when you are clinically eligible, as determined by the researcher, to take part in the qualifying clinical trial.

Routine patient care costs are the costs of Medically Necessary health care services that are incurred as a result of the treatment being provided for purposes of the clinical trial. Routine patient care costs for qualifying clinical trials include:

- Covered Health Care Services for which Benefits are typically provided absent a clinical trial.
- Covered Health Care Services required solely for the following:
 - The provision of the Experimental or Investigational Service(s) or item.
 - The clinically appropriate monitoring of the effects of the service or item, or
 - The prevention of complications.
- Covered Health Care Services needed for reasonable and necessary care arising from the receipt of an Experimental or Investigational Service(s) or item.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service(s) or item. The only exceptions to this are:
 - Certain *Category B* devices.
 - Certain promising interventions for patients with terminal illnesses.
 - Other items and services that meet specified criteria in accordance with our medical and drug policies.
- Items and services provided solely to meet data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that clearly does not meet widely accepted and established standards of care for a particular diagnosis.
- Items and services provided by the research sponsors free of charge for any person taking part in the trial.

With respect to cancer or other life-threatening diseases or conditions, a qualifying clinical trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial. It takes place in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition. It meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease or musculoskeletal disorders of the spine, hip and knees and other diseases or disorders which are not life-threatening, a qualifying clinical trial is a Phase I, Phase II, or Phase III clinical trial. It takes place in relation to the detection or treatment of such non-life-threatening disease or disorder. It meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
 - *National Institutes of Health (NIH)*. (Includes *National Cancer Institute (NCI)*.)
 - *Centers for Disease Control and Prevention (CDC)*.
 - *Agency for Healthcare Research and Quality (AHRQ)*.

- *Centers for Medicare and Medicaid Services (CMS).*
- A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA)*. A "cooperative group" for the purpose of this Benefit includes the:
 - ◆ *National Cancer Institute Clinical Cooperative Group;*
 - ◆ *National Cancer Institute Community Clinical Oncology Program;*
 - ◆ *AIDS Clinical Trials Group;* and
 - ◆ *Community Programs for Clinical Research in AIDs.*
- A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.
- 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. The peer review system is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
 - ◆ Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*.
 - ◆ Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation takes place under an investigational new drug application reviewed by the *U.S. Food and Drug Administration*.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- The treatment being provided in a clinical trial is approved by an institutional review board of an institution in the State which has a multiple project assurance contract approved by the *Office of Protection from Research Risks of the National Institutes of Health*. An entity seeking coverage for treatment in a clinical trial approved by such institutional review board shall post electronically and keep up-to-date a list of the clinical trials meeting the requirements for a qualifying clinical trial as described above.

For the purpose of this Benefit, a "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 federal *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.

- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Care Service and is not otherwise excluded under the Policy.

5. Congenital Heart Disease (CHD) Surgeries

CHD surgeries which are ordered by a Physician. CHD surgical procedures include surgeries to treat conditions such as:

- Coarctation of the aorta.
- Aortic stenosis.
- Tetralogy of fallot.

- Transposition of the great vessels.
- Hypoplastic left or right heart syndrome.

Benefits include the facility charge and the charge for supplies and equipment. Benefits for Physician services are described under *Physician Fees for Surgical and Medical Services*.

Surgery may be performed as open or closed surgical procedures or may be performed through interventional cardiac catheterization.

We have specific guidelines regarding Benefits for CHD services. These guidelines provide information and access to CHD Benefit management services to assist in selecting a center appropriate for your care. Services include access to specialized CHD nurses to provide support throughout the surgery and recovery process and to assist in making treatment decisions.

Contact us at the telephone number on your ID card for information about these guidelines.

6. Dental Services - Accident Only

Dental services when all of the following are true:

- Treatment is needed because of accidental damage.
- You receive dental services from a health care provider practicing within the lawful scope of the health care provider's license under the *Maryland Health Occupations Article*.
- The dental damage is severe enough that first contact with a health care provider happened within 72 hours of the accident. (You may request this time period be longer if you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

Please note that dental damage that happens as a result of normal activities of daily living or extraordinary use of the teeth is not considered an accidental Injury. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

Dental services to repair damage caused by accidental Injury must follow these time-frames:

- Treatment is started within three months of the accident, or if not a Covered Person at the time of the accident, within the first three months of coverage under the Policy, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care).
- Treatment must be completed within 12 months of the accident, or if not a Covered Person at the time of the accident, within the first 12 months of coverage under the Policy.

Benefits for treatment of accidental Injury are limited to the following:

- Emergency exam.
- Diagnostic X-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.
- Prefabricated post and core.
- Simple minimal restorative procedures (fillings).
- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.

- Replacement of lost teeth due to Injury with implant, dentures or bridges.

7. Diabetes Services

Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services when services are ordered by a Physician and provided by appropriately licensed, certified or registered health care professionals. The provider certifies the services are necessary for the treatment of:

- Insulin using diabetes;
- Non-insulin using diabetes;
- Elevated or impaired blood glucose levels induced by pregnancy; or
- Elevated or impaired blood glucose levels induced by prediabetes in accordance with the *American Diabetes Association's* standards.

Diabetes self-management training includes training provided to you after the diagnosis of diabetes and or Pregnancy induced elevated or impaired blood glucose levels in the care and management of those conditions, including nutritional counseling and proper use of the diabetic self-management items listed below. Benefits are also provided for additional training upon diagnosis of a significant change in medical condition that requires a change in the self-management regime, and periodic continuing education training as warranted by the development of new techniques and treatment for diabetes.

Benefits also include medical eye exams (dilated retinal exams) and preventive foot care for diabetes.

Diabetic Self-Management Items

Insulin pumps, continuous glucose monitors and all other medically appropriate and necessary equipment and supplies based upon your medical needs for the treatment of:

- Insulin using diabetes;
- Non-insulin using diabetes;
- Elevated or impaired blood glucose levels induced by pregnancy; or
- Elevated or impaired blood glucose levels induced by prediabetes in accordance with the *American Diabetes Association's* standards.

An insulin pump is subject to all the conditions of coverage stated under *Durable Medical Equipment (DME), Orthotics and Supplies*. Benefits for blood glucose meters including continuous glucose monitors insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described under the *Outpatient Prescription Drug Rider*.

8. Durable Medical Equipment (DME), Orthotics and Supplies

Benefits are provided for DME and certain orthotics and supplies. If more than one item can meet your functional needs, Benefits are available only for the item that meets the minimum specifications for your needs. If you purchase an item that exceeds these minimum specifications, we will pay only the amount that we would have paid for the item that meets the minimum specifications, and you will be responsible for paying any difference in cost.

DME and Supplies

Examples of DME and supplies include:

- Equipment to help mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Negative pressure wound therapy pumps (wound vacuums).
- Mechanical equipment needed for the treatment of long term or sudden respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related needed supplies as described under *Diabetes Services*.
- External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this *Certificate*.

Benefits also include dedicated speech generating devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly due to Sickness or Injury. Benefits for the purchase of these devices are available only after completing a required three-month rental period. Benefits are limited as stated in the *Schedule of Benefits*.

Orthotics

Orthotic braces, including needed changes to shoes to fit braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are a Covered Health Care Service.

We will decide if the equipment should be purchased or rented.

Benefits are available for repairs and replacement, except as described in *Section 2: Exclusions and Limitations*, under *Medical Supplies and Equipment*.

These Benefits apply to external DME. Unless otherwise excluded, items that are fully implanted into the body are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Service categories in this *Certificate*.

9. Emergency Health Care Services - Outpatient

Services that are required to stabilize or begin treatment in an Emergency. Emergency Health Care Services must be received on an outpatient basis at a Hospital or Alternate Facility.

Benefits include the facility charge, supplies and all professional services required to stabilize your condition and/or begin treatment. This includes placement in an observation bed to monitor your condition (rather than being admitted to a Hospital for an Inpatient Stay).

If Emergency Health Care Services provided by an out-of-Network provider include surgical services, you may elect to receive outpatient follow-up care from the out-of-Network provider subject to the Network cost-sharing shown in the *Schedule of Benefits* if the follow-up care is:

- Medically Necessary,
- Directly related to the condition for which the surgical procedure was performed, and
- Provided in consultation with your Network Physician.

Unless we authorized, directed, referred or otherwise allowed the Covered Person to utilize the emergency facility, we will require reimbursement from you for any Benefits paid under this section if the condition for which services are rendered does not meet the definition of an Emergency.

10. Gender Dysphoria

Benefits for the treatment of gender dysphoria provided by or under the direction of a Physician.

For the purpose of this Benefit, "gender dysphoria" is a disorder characterized by the specific diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

11. Habilitative Services

Except for habilitative services provided in early intervention and school services, habilitative services for Enrolled Dependent children from 0 - 19 years old. Coverage is provided through the end of the month in which the child turns 19 years old.

"Habilitative services" means services and devices, including occupational therapy, physical therapy, and speech therapy, that help a child keep, learn, or improve skills and functioning for daily living. The limits for physical, speech and occupational therapy do not apply to the visits received in connection with this benefit.

12. Hearing Aids

Hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). These are electronic amplifying devices designed to bring sound more effectively into the ear. These consist of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased due to a written recommendation by a Physician. Benefits are provided for the hearing aid and associated fitting charges and testing.

If more than one type of hearing aid can meet your functional needs, Benefits are available only for the hearing aid that meets the minimum specifications for your needs. You may choose a hearing aid that is priced higher than a hearing aid that meets the minimum specification for your needs, however, you will be required to pay the difference between the price of the hearing aid you select and that which meets the minimum specification for your needs.

Benefits include hearing aids intended for children that are of design and circuitry to optimize audibility and listening skills in the environment commonly experienced by children and are non-disposable. Such hearing aids must be prescribed, fitted and dispensed by a licensed audiologist.

Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Services categories in this Certificate. They are only available if you have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals prevent the use of a wearable hearing aid.
- Hearing loss severe enough that it would not be remedied by a wearable hearing aid or, for Enrolled Dependent children, when a wearable hearing aid would not be suitable to optimize audibility and listening skills in the environment commonly experienced by children.

13. Home Health Care

Services received from a Home Health Agency that meets the following requirements:

- Except for the services required by state law listed below, services that consist of a plan of treatment that is established and approved in writing by your Physician where you would need to be admitted to an inpatient setting if home health care was not provided; and

- Provided in your home by a person licensed under the *Health Occupations Article* of the Maryland Code.
- Do not constitute Custodial Care; and
- Are not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair.

In accordance with state law, home health care services are also available for the following:

- One home visit scheduled to occur within 24 hours after discharge from the Hospital or outpatient health care facility for a Covered Person who received less than 48 hours of inpatient hospitalization following the surgical removal of a testicle, or who undergoes such procedures on an outpatient basis. We will provide Benefits for an additional home visit if prescribed by the Covered Person's attending Physician.
- One home visit scheduled to occur within 24 hours after discharge from the Hospital or outpatient health care facility for a Covered Person who received less than 48 hours of inpatient hospitalization following a mastectomy, or who undergoes such procedures on an outpatient basis. We will provide Benefits for 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 48 hours of inpatient hospitalization, we will provide Benefits for a home visit if prescribed by the Covered Person's attending Physician.

For the purpose of this Benefit, "mastectomy" means the surgical removal of all or part of the breast as a result of breast cancer.

- One home visit and an additional home visit when prescribed by a Physician for a mother and newborn child following discharge from a Hospital who received less than 48 hours of an Inpatient Stay for an uncomplicated vaginal delivery or 96 hours for an uncomplicated cesarean delivery. The home visit will occur within 24 hours of discharge.
- One home visit when prescribed by a Physician for a mother and newborn child following discharge from a Hospital after a 48 hour Inpatient Stay for an uncomplicated vaginal delivery or 96 hours for an uncomplicated cesarean delivery.

Such home visits shall be provided with the following conditions:

- They will comply with generally accepted standards of nursing practice for home care of a mother and newborn child;
- They will be provided by registered nurse with at least one year of experience in maternal and child health nursing or community health nursing with an emphasis on maternal and child health; and
- They will include any services required by the attending health care provider.

14. Hospice Care

Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill, including physical, psychological, social and spiritual care.

For the purpose of this Benefit, the following terms have the following meanings:

- "Family counseling" means counseling provided to the immediate family or family caregiver of the terminally ill person for the purpose of learning to care for the terminally ill person and to adjust to the death of the terminally ill person.
- "Family caregiver" means a relative by blood, marriage, or adoption who lives with or is the primary caregiver of the terminally ill person.

- "Immediate family" means the spouse, parents, siblings, grandparents, and children of a terminally ill person.
- "Terminally ill" means a medical prognosis given by a Physician that a Covered Person's life expectancy is six months or less.

Hospice care includes the following specific services:

- Inpatient and outpatient services.
- Part-time nursing care by or supervised by a registered graduate nurse.
- Counseling, including dietary counseling, for the terminally ill person.
- Family counseling for family caregivers and the immediate family before the death of the terminally ill person.
- All medical supplies, medications and equipment required to maintain the comfort and manage the pain of the terminally ill person.

Benefits are available when you receive hospice care from a licensed hospice agency.

You can call us at the telephone number on your ID card for information about our guidelines for hospice care.

15. Hospital - Inpatient Stay

Services and supplies provided during an Inpatient Stay in a Hospital.

Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)
- Hospital admission charges.
- A hearing loss screening for a newborn child prior to discharge from the Hospital.

Benefits include at least 48 hours of inpatient hospitalization following a Covered Person's mastectomy.

For the purpose of this Benefit, "mastectomy" means the surgical removal of all or part of the breast as a result of breast cancer.

16. Infertility Services

Services for the treatment of infertility when provided by or under the care or supervision of a Physician, limited to the following procedures:

- Ovulation induction (or controlled ovarian stimulation).
- Insemination procedures (artificial insemination (AI) and intrauterine insemination (IUI)).
- Assisted Reproductive Technologies (ART).
- Pharmaceutical Products for the treatment of infertility that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in your home.

To be eligible for Benefits, you must meet all of the following:

- You are not able to become pregnant after the following periods of time of regular unprotected intercourse or therapeutic donor insemination:
 - One year, if you are a female under age 35.
 - Six months, if you are a female age 35 or older.
- You are a female under age 44.
- You have infertility not related to voluntary sterilization or to failed reversal of voluntary sterilization.

For the purposes of this Benefit, "therapeutic donor insemination" means insemination with a donor sperm sample for the purpose of conceiving a child.

NOTE: Infertility Services as described above does not include in vitro fertilization. See below under *Additional Benefits Required by Maryland Law* for a description of the in vitro fertilization Benefits available to you.

17. Lab, X-Ray and Diagnostic - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office include:

- Lab and radiology/X-ray.
- Mammography.
- Bone mass measurement testing for diagnostic and treatment purposes. Benefits for bone mass measurement performed for prevention of osteoporosis is provided as described under *Preventive Care Services*.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)
- Genetic Testing ordered by a Physician which results in available medical treatment options following Genetic Counseling.
- Presumptive Drug Tests and Definitive Drug Tests.

Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services*.

CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Major Diagnostic and Imaging - Outpatient*.

18. Major Diagnostic and Imaging - Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

19. Mental Health Care and Substance-Related and Addictive Disorders Services

Mental Health Care and Substance-Related and Addictive Disorders Services include those received on an inpatient or outpatient basis in a Hospital, Residential Treatment facility, an Alternate Facility or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider, which includes a licensed, registered or certified mental health and substance-related and addictive disorders practitioner, a licensed clinical professional counselor, a licensed clinical marriage and family therapist, a licensed clinical alcohol and drug counselor or a licensed clinical professional art therapist.

Benefits include the following levels of care:

- Inpatient treatment.
- Inpatient professional fees.
- Residential Treatment.
- Transitional Living services.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment, including professional charges in a provider's office or other professional setting.
- Outpatient treatment.

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment and treatment planning (Including psychological and neuropsychological testing for diagnostic purposes, diagnostic evaluation, opioid treatment services, medication evaluation and management).
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Provider-based case management services.
- Crisis intervention.
- Residential Crisis Services.
- Mental Health Care Services for Autism Spectrum Disorder (including Intensive Behavioral Therapies such as *Applied Behavior Analysis (ABA)*) that are the following:
 - Focused on the treatment of core deficits of Autism Spectrum Disorder.
 - Provided by a *Board Certified Behavior Analyst (BCBA)* or other qualified provider under the appropriate supervision.
 - Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.

This section describes only the behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Care Service for which

Benefits are available under the applicable medical Covered Health Care Services categories in this *Certificate*.

Benefits for Medically Necessary behavioral health care services provided by a participating provider will be covered when a member who is a student and that service is provided at a public school or through a school-based health care center. In this instance, the following words have the meanings indicated below:

- "Behavioral health counseling services" means prevention, intervention and treatment services for the social-emotional, psychological, behavioral and physical health of students, including mental health and substance-related and addictive disorders.
- "Health care provider" has the meaning stated in § 20-104 of the Health - General Article.

The Mental Health/Substance-Related and Addictive Disorders Designee provides administrative services for all levels of care.

We encourage you to contact the Mental Health/Substance-Related and Addictive Disorders Designee for referrals to providers and coordination of care by contacting us at www.myuhc.com or the telephone number on your ID card.

20. Ostomy and Urologic Supplies

Ostomy Supplies

Benefits are provided for all Medically Necessary and appropriate equipment and supplies used for the treatment of ostomies, including flanges, collection bags, clamps, irrigation devices, sanitizing products, ostomy rings, ostomy belts and catheters used for the drainage of urostomies.

Urologic Supplies

Benefits for urologic supplies required by Covered Persons with permanent incontinence including, but not limited to, pouches, barriers and catheters. Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive and adhesive removers.

21. Pharmaceutical Products - Outpatient

Pharmaceutical Products for Covered Health Care Services administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in your home.

Benefits are provided for Pharmaceutical Products which, due to their traits (as determined by us), are administered or directly supervised by a qualified provider or licensed/certified health professional. Depending on where the Pharmaceutical Product is administered, Benefits will be provided for administration of the Pharmaceutical Product under the corresponding Benefit category in this *Certificate*. Benefits for medication normally available by a prescription or order or refill are provided as described under your *Outpatient Prescription Drug Rider*.

If you require certain Pharmaceutical Products, including specialty Pharmaceutical Products, we may direct you to a Designated Dispensing Entity. Such Dispensing Entities may include an outpatient pharmacy, specialty pharmacy, Home Health Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

If you/your provider are directed to a Designated Dispensing Entity and you/your provider choose not to get your Pharmaceutical Product from a Designated Dispensing Entity, Network Benefits are not available for that Pharmaceutical Product.

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you must use a different Pharmaceutical Product and/or prescription drug product first. You may find out whether a particular Pharmaceutical Product is subject to step therapy requirements by contacting us at www.myuhc.com or the telephone number on your ID card.

A step therapy requirement may not be imposed if:

- The step therapy drug has not been approved by the *U.S. Food and Drug Administration (FDA)* for the medical condition being treated; or
- The prescribing provider provides supporting medical information to us that a Prescription Drug Product:
 - Was ordered by a prescribing provider for the Covered Person within the past 180 days; and
 - Based on the professional judgment of the prescribing provider, was effective in treating the Covered Person's medical condition.
- The prescription drug has been approved by the FDA and:
 - Is being used to treat the Covered Person's stage four advanced metastatic cancer; and
 - Use of the prescription drug is consistent with the FDA-approved indication or the *National Comprehensive Cancer Network Drugs & Biologics Compendium* indication for the for the treatment of stage four advanced metastatic cancer; and
 - Is supported by peer-reviewed medical literature.

22. Physician Fees for Surgical and Medical Services

Physician fees for surgical procedures and other medical services received on an outpatient or inpatient basis in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls.

23. Physician's Office Services - Sickness and Injury

Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided regardless of whether the Physician's office is freestanding, located in a clinic or located in a Hospital.

Covered Health Care Services include medical education services that are provided in a Physician's office by appropriately licensed or registered health care professionals when both of the following are true:

- Education is required for a disease in which patient self-management is a part of treatment.
- There is a lack of knowledge regarding the disease which requires the help of a trained health professional.

Covered Health Care Services include Genetic Counseling.

Benefits include allergy injections.

Benefits under this section include the insertion or removal of any contraceptive drug or device and associated Medically Necessary exam when performed in a Physician's office. When these services are performed outside the Physician office, Benefits are provided in the same manner and at the same level as those for any other Covered Health Care Service.

Covered Health Care Services for preventive care provided in a Physician's office are described under *Preventive Care Services*.

Benefits for CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under, *Major Diagnostic and Imaging - Outpatient*.

When a test is performed or a sample is drawn in the Physician's office, Benefits for the analysis or testing of a lab, radiology/X-ray or other diagnostic service, whether performed in or out of the Physician's office, are described under *Lab, X-ray and Diagnostic - Outpatient*.

24. Pregnancy - Maternity Services

Benefits for Pregnancy include all maternity-related medical services for prenatal care, postnatal care, delivery and any related complications. Benefits include those of a certified nurse-midwife or pediatric nurse practitioner.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Care Services include related tests and treatment.

We also have special prenatal programs to help during Pregnancy. They are voluntary and there is no extra cost for taking part in the program. To sign up, you should notify us during the first trimester, but no later than one month prior to the expected date of delivery. It is important that you notify us regarding your Pregnancy.

We will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following an uncomplicated normal vaginal delivery.
- 96 hours for the mother and newborn child following an uncomplicated cesarean section delivery.

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames. In the event of such a shorter stay, we will provide Benefits for at least one home care visit as described above under *Home Health Care*. If you and your newborn child remain in the Hospital for at least as long as the minimum Inpatient Stays as shown above, a single home visit will be provided if prescribed by the attending Physician as described above under *Home Health Care*.

In addition, whenever you are required to remain hospitalized after childbirth for medical reasons and you request that your newborn remain in the Hospital, we will pay the cost of additional hospitalization for the newborn for up to four days as required by state law.

25. Preventive Care Services

Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- Evidence-based items or services, inclusive of current recommendations for breast cancer, that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*. Note that recommendations of the *United States Preventive Services Task Force* regarding breast cancer screening, mammography and prevention issued in or around November 2009 are not considered to be current.
- Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*.
- 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*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

Benefits defined under the *Health Resources and Services Administration (HRSA)* requirement include one breast pump per Pregnancy in conjunction with childbirth. Breast pumps must be ordered by or provided by a Physician. You can find more information on how to access Benefits for breast pumps by contacting us at www.myuhc.com or the telephone number on your ID card.

If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump. We will determine the following:

- Which pump is the most cost effective.
- Whether the pump should be purchased or rented (and the duration of any rental).
- Timing of purchase or rental.

Benefits for the services listed below are required under Maryland law.

- Breast cancer screening, including digital tomosynthesis when the treating provider determines it is Medically Necessary, in accordance with the latest screening guidelines issued by the *American Cancer Society*. Breast cancer screening is not subject to a deductible, as described in the *Schedule of Benefits*.
- Screening colonoscopy or sigmoidoscopy and other colorectal cancer screening tests in accordance with the latest screening guidelines issued by the *American Cancer Society*.
- Prostate cancer screening including digital rectal exams and prostate-specific antigen (PSA) blood tests for:
 - Male Covered Persons who are between the ages of 40 and 75; or
 - When used for the purpose of guiding patient management in monitoring the response to prostate cancer treatment; or
 - When used for staging in determining the need for a bone scan in patients with prostate cancer; or
 - When used for Covered Persons who are at high risk for prostate cancer.
- Bone mineral density tests including a bone mass measurement (a radiologic or radioisotopic procedure, or other scientifically proven technology) for the prevention of osteoporosis when the bone mass measurement is requested by a Physician, and:
 - You are an estrogen deficient individual at risk for osteoporosis; or
 - You show a specific sign suggestive of spinal osteoporosis, including roentgenographic osteopenia or roentgenographic evidence suggestive of collapse, wedging, or ballooning of one or more thoracic or lumbar vertebral bodies and are a candidate for therapeutic intervention or for an extensive diagnostic evaluation for metabolic bone disease; or
 - You are receiving long-term glucocorticoid (steroid) therapy; or
 - You have hyperparathyroidism; or
 - You are being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.
- An annual chlamydia screening test for:
 - Women who are (i) younger than 20 years old who are sexually active, and (ii) at least 20 years old who have multiple risk factors; and
 - Men who have multiple risk factors.

"Multiple risk factors" means having a prior history of a sexually transmitted disease, new or multiple sex partners, inconsistent use of barrier contraceptives, or cervical ectopy.

"Chlamydia screening test" means any laboratory test that:

- Specifically detects for infection by one or more agents of chlamydia trachomatis; and
- Is approved for this purpose by the *U.S. Food and Drug Administration (FDA)*.
- A human papillomavirus screening test at the testing intervals recommended for cervical cytology screenings by the *American College of Obstetricians and Gynecologists*.
 - "Human papillomavirus screening test" means any laboratory test that:
 - ◆ Specifically detects for infection by one or more agents of the human papillomavirus; and
 - ◆ Is approved for this purpose by the *U.S. Food and Drug Administration (FDA)*.
- Instruction by a licensed health care provider on fertility awareness-based methods.
 - For the purpose of this Benefit, "fertility awareness-based methods" means the methods of identifying times of fertility and infertility by an individual to avoid pregnancy, including:
 - ◆ Cervical mucus methods;
 - ◆ Sympto-thermal or sympto-hormonal methods;
 - ◆ The standard days method; and
 - ◆ The lactational amenorrhea method.

26. Prosthetic Devices

External prosthetic devices that replace, in whole or in part, a limb or a body part, limited to:

- Artificial arms, legs, feet and hands.
- Artificial face, eyes, ears and nose.
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras. Benefits for the treatment of lymphedema are also covered as described under *Lymphedema Services*.
- Components of prosthetic devices.

Benefits are provided only for external prosthetic devices and do not include any device that is fully implanted into the body. Internal prosthetics are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Service categories in this *Certificate*.

A prosthetic device or component will be considered a Covered Health Care Service if it meets the requirements of medical necessity established under the Medicare coverage database. If you purchase a prosthetic device that exceeds these minimum specifications, we will pay only the amount that we would have paid for the prosthetic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

The prosthetic device must be ordered or provided by, or under the direction of a Physician.

Benefits are available for repairs and replacement, except as described in *Section 2: Exclusions and Limitations*, under *Devices, Appliances and Prosthetics*.

27. Reconstructive Procedures

Reconstructive procedures when the primary purpose of the procedure is either of the following:

- Treatment of a medical condition.
- Improvement or restoration of physiologic function.

Reconstructive procedures include surgery or other procedures which are related to an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that you may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Please note that Benefits for reconstructive procedures include reconstructive breast surgery following mastectomy, including complications of all stages of mastectomy, as well as all stages of reconstructive breast surgery of the non-affected breast to achieve symmetry. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including treatment of complications, including lymphedemas in a manner determined in consultation with the attending Physician and the patient, are provided in the same manner and at the same level as those for any other Covered Health Care Service. You can call us at the telephone number on your ID card for more information about Benefits for mastectomy-related services. For the purpose of this Benefit, the following terms have the following meaning:

- "Mastectomy" means the surgical removal of all or part of a breast.
- "Reconstructive breast surgery" means surgery performed as a result of a mastectomy to reestablish symmetry between the two breasts.

28. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

Short-term outpatient rehabilitation services limited to:

- Physical therapy.
- Occupational therapy.
- Manipulative Treatment.
- Speech therapy.
- Pulmonary rehabilitation therapy.
- Cardiac rehabilitation therapy.
- Post-cochlear implant aural therapy.
- Cognitive rehabilitation therapy.

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Rehabilitative services provided in your home by a Home Health Agency are provided as described under *Home Health Care*. Rehabilitative services provided in your home other than by a Home Health Agency are provided as described under this section.

Benefits can be denied or shortened when either of the following applies:

- You are not progressing in goal-directed rehabilitation services.

- Rehabilitation goals have previously been met.

Benefits are not available for maintenance/preventive treatment.

For outpatient rehabilitative services for speech therapy we will pay Benefits for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, or Congenital Anomaly. We will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or stroke.

29. Scopic Procedures - Outpatient Diagnostic and Therapeutic

Diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include:

- Colonoscopy.
- Sigmoidoscopy.
- Diagnostic endoscopy.

Please note that Benefits do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for all other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Benefits that apply to certain preventive screenings are described under *Preventive Care Services*.

30. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Services and supplies provided during an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Please note that Benefits are available only if both of the following are true:

- If the first confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a cost effective option to an Inpatient Stay in a Hospital.
- You will receive Skilled Care services that are not primarily Custodial Care.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management.

Benefits can be denied or shortened when either of the following applies:

- You are not progressing in goal-directed rehabilitation services.

- Discharge rehabilitation goals have previously been met.

31. Surgery - Outpatient

Surgery and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits include certain scopic procedures. Examples of surgical scopic procedures include:

- Arthroscopy.
- Laparoscopy.
- Bronchoscopy.
- Hysteroscopy.

Examples of surgical procedures performed in a Physician's office are mole removal, ear wax removal, and cast application.

Voluntary sterilization, including male sterilization, is covered under this benefit.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

32. Therapeutic Treatments - Outpatient

Therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including:

- Dialysis (both hemodialysis and peritoneal dialysis).
- Intravenous chemotherapy or other intravenous infusion therapy.
- Radiation oncology.

Covered Health Care Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered health care professionals when both of the following are true:

- Education is required for a disease in which patient self-management is a part of treatment.
- There is a lack of knowledge regarding the disease which requires the help of a trained health professional.

Benefits include:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.

33. Transplantation Services

Organ and tissue transplants including CAR-T cell therapy for malignancies when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Care Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include:

- Bone marrow including CAR-T cell therapy for malignancies.
- Heart.
- Heart/lung.
- Lung.
- Kidney.
- Kidney/pancreas.
- Liver.
- Liver/small intestine.
- Pancreas.
- Small intestine.
- Cornea.

Donor costs related to transplantation are Covered Health Care Services and are payable through the organ recipient's coverage under the Policy, limited to donor:

- Identification.
- Evaluation.
- Organ removal.
- Direct follow-up care.

You can call us at the telephone number on your ID card for information about our specific guidelines regarding Benefits for transplant services.

34. Urgent Care Center Services

Covered Health Care Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services - Sickness and Injury*.

35. Urinary Catheters

Benefits are available for indwelling and intermittent urinary catheters for incontinence or retention.

Benefits include related urologic supplies for indwelling catheters limited to:

- Urinary drainage bag and insertion tray (kit).
- Anchoring device.
- Irrigation tubing set.

36. Virtual Visits

Virtual visits for Covered Health Care Services that include the diagnosis and treatment of less serious medical conditions through live audio with video technology or audio only. Virtual visits provide communication of medical information in real-time between the patient and a distant Physician or health specialist, through use of live audio with video technology or audio only outside of a medical facility (for example, from home or from work).

Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting us at www.myuhc.com or the telephone number on your ID card.

Please Note: Not all medical conditions can be treated through virtual visits. The Designated Virtual Network Provider will identify any condition for which treatment by in-person Physician contact is needed.

Benefits do not include email, fax and standard telephone calls, or for telehealth/telemedicine visits that occur within medical facilities (CMS defined originating facilities).

37. Wigs

Wigs and other scalp hair prosthesis regardless of the reason for hair loss other than loss of natural hair resulting from chemotherapy or radiation treatment for cancer for which Benefits are provided as described below under *Hair Prosthesis*.

Additional Benefits Required By Maryland Law

38. Amino Acid-Based Elemental Formula

Benefits will be provided for amino acid-based elemental formula, regardless of delivery method, for the diagnosis and treatment of:

- Immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins;
- Severe food protein induced enterocolitis syndrome;
- Eosinophilic disorders (as evidenced by results of a biopsy); and
- Impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.

39. Bones of Face, Neck, and Head

Services for diagnostic and surgical procedures involving bones or joints of the face, neck, or head to treat conditions caused by congenital deformity, Sickness or Injury. Note: Covered Health Care Services do not include treatment of the teeth or gums, intraoral prosthetic devices or surgical procedures for cosmetic purposes.

40. Child Wellness Services

Benefits for child wellness services may not be subject to a deductible and include:

- Office visits and related expenses for childhood and adolescent immunizations recommended by the *Advisory Committee on Immunization Practices* of the *Centers for Disease Control and Prevention*;

- Services for hereditary and metabolic newborn screening and follow-up visits from birth to four weeks of age including visits for the collection of adequate samples, the first of which is to be collected before two weeks of age;
- Universal hearing screening of newborns provided by a Hospital before discharge;
- All visits and cost of services for age -appropriate screening tests for tuberculosis, anemia, lead toxicity, hearing and vision as determined by the *American Academy of Pediatrics*;
- Visits for obesity evaluation and management.
- All visits for and costs of developmental screening as recommended by the *American Academy of Pediatrics*.
- Physical examinations, developmental assessments, parental anticipatory guidance and laboratory tests considered necessary by the Physician for services described above.

41. Treatment of Cleft Lip or Palate or Both

Benefits for inpatient or outpatient orthodontic services, oral surgery, and otologic, audiological, and speech/language treatment for a Covered Person in connection with the birth defect of cleft lip, cleft palate, or both. Services must be provided by or under the direction of a Physician.

42. Dental Services - Hospital and Alternate Facility Health Services Related to Dental Care

Benefits for general anesthesia and associated Hospital or Alternate Facility charges along with dental care provided to a Covered Person if the Covered Person:

- (A) Is a child seven years of age or younger or is developmentally disabled;
- Is an individual for whom a successful result cannot be expected from dental care provided under a local anesthesia because of a physical, intellectual, or other medically compromising condition; and
 - Is an individual for whom a superior result can be expected from dental care provided under general anesthesia; or
- (B) Is an extremely uncooperative, fearful, or uncommunicative child who is 17 years of age or younger with dental needs of such magnitude that treatment should not be delayed or deferred; and
- Is an individual for whom lack of treatment can be expected to result in oral pain, infection, loss of teeth, or other increased oral or dental morbidity.
 - Such services must be provided under the direction of a Physician or dentist. Benefits are not provided for expenses for the diagnosis or treatment of dental disease.

43. Hair Prosthesis

A single hair prosthesis for loss of natural hair resulting from chemotherapy or radiation treatment for cancer when prescribed by the resident oncologist.

44. In Vitro Fertilization

Benefits for outpatient expenses for the treatment of infertility through the use of in vitro fertilization procedures.

This Benefit is available if:

- For a patient whose spouse is of the opposite sex, the patient's oocytes are fertilized with the sperm of the patient's spouse, unless:
 - The patient's spouse is unable to produce and deliver functional sperm; and
 - The inability to produce and deliver functional sperm does not result from a vasectomy or other method of voluntary sterilization.
- The patient and the patient's spouse have a history of involuntary infertility which may be demonstrated by a history of:
 - The patient and the patient's spouse are of the opposite sexes and intercourse of at least two years duration has failed to result in Pregnancy; or
 - The patient and the patient's spouse are of the same sex and six attempts of artificial insemination over the course of two years has failed to result in Pregnancy; or
- The diagnosis of infertility associated with any of the following medical conditions:
 - Endometriosis,
 - Exposure before birth to diethylstilbestrol, commonly known as DES,
 - Blockage of or surgical removal of one or both fallopian tubes, or
 - Abnormal male factors, including oligospermia, contributing to the infertility.
- The patient has been unable to attain a successful Pregnancy through less costly infertility treatments covered under the Policy.
- The in vitro fertilization procedures are performed at medical facilities that conform to the applicable guidelines or minimum standards issued by the *American College of Obstetricians and Gynecologists* guidelines for in vitro fertilization clinics, the *American Fertility Society* minimal standards for programs of in vitro fertilization, or the *American Society for Reproductive Medicine*.

See *Schedule of Benefits* for Benefit conditions and maximum Benefit.

45. Lymphedema Services

Coverage is provided for the medically necessary diagnosis, evaluation and treatment of lymphedema, including equipment, supplies, complex decongestive therapy, gradient compression garments, and self-management training and education. Gradient compression garment means a garment that is used for the treatment of lymphedema, requires a prescription and is custom fitted for the Enrolled Person for whom the garment is prescribed. Gradient compression garment does not include disposable medical supplies, including over-the-counter compression or elastic knee-high or other stocking products. Coverage for the treatment of lymphedema is subject to the same cost-sharing requirements as benefits with similar coverage.

46. Medical Foods

Benefits are provided for medical foods and low protein modified food products when prescribed and administered under the direction of a Physician for the treatment of inherited metabolic diseases caused by an inherited abnormality of body chemistry.

"Low protein modified food product" means a food product that is:

- Specially formulated to have less than one gram of protein per serving; and
- Intended to be used under the direction of a Physician for the dietary treatment of an inherited metabolic disease.

Low protein modified food product does not include a natural food that is naturally low in protein.

"Medical food" means a food that is:

- Intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation; and

Formulated to be consumed or administered enterally under the direction of a Physician.

47. Standard Fertility Preservation Procedures

Standard fertility preservation procedures will be covered when medically necessary to preserve fertility due to a medical treatment that may directly or indirectly cause iatrogenic infertility.

"Iatrogenic infertility" means impairment of fertility caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment affecting the reproductive organs or processes.

"Medical treatment that may directly or indirectly cause iatrogenic infertility" means medical treatment with a likely side effect of infertility as established by the *American Society for Reproductive Medicine*, the *American College of Obstetricians and Gynecologists*, or the *American Society of Clinical Oncology*.

"Standard fertility preservation procedures" means procedures to preserve fertility that are consistent with established medical practices and professional guidelines published by the *American Society for Reproductive Medicine*, the *American College of Obstetricians and Gynecologists*, or the *American Society of Clinical Oncology*.

- These procedures include sperm and oocyte cryopreservation and evaluations, laboratory assessments, medications, and treatments associated with sperm and oocyte cryopreservation.
- These procedures do not include the storage of sperm or oocytes.

48. Surgical Morbid Obesity Treatment

Surgical treatment of morbid obesity that is:

- Recognized by the *National Institutes of Health (NIH)* as effective for the long-term reversal of morbid obesity; and
- Consistent with criteria approved by the *National Institutes of Health*.

For purposes of this Benefit, the term "morbid obesity" is defined as a body mass index that is:

- Greater than 40 kilograms per meter squared; or
- Equal to or greater than 35 kilograms per meter squared with a comorbid medical condition including hypertension, a cardiopulmonary condition, sleep apnea, or diabetes.

"Body mass index" is defined as a practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

49. Telemedicine Services

Covered Health Care Services delivered through the use of interactive audio, video, or other telecommunications or electronic technology by a health care provider to deliver a health care service that is within the scope of practice of the health care provider at a location other than the location at which the patient is located, including the patient's home setting. Telemedicine Services includes diagnosis, consultation, and treatment of mental health care, substance-related and addictive disorders.

Telemedicine does not include: 1) An audio-only telephone conversation between a health care provider and a patient; 2) An electronic mail message between a health care provider and a patient; or 3) A facsimile transmission between a health care provider and a patient.

Section 2: Exclusions and Limitations

How Do We Use Headings in this Section?

To help you find exclusions, we use headings (for example *A. Alternative Treatments* below). The headings group services, treatments, items, or supplies that fall into a similar category. Exclusions appear under the headings. A heading does not create, define, change, limit or expand an exclusion. All exclusions in this section apply to you.

We Do Not Pay Benefits for Exclusions

We will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Care Services, except as may be specifically provided for in *Section 1: Covered Health Care Services* or through a Rider to the Policy.

Where Are Benefit Limitations Shown?

When Benefits are limited within any of the Covered Health Care Service categories described in *Section 1: Covered Health Care Services*, those limits are stated in the corresponding Covered Health Care Service category in the *Schedule of Benefits*. Limits may also apply to some Covered Health Care Services that fall under more than one Covered Health Care Service category. When this occurs, those limits are also stated in the *Schedule of Benefits* table. Please review all limits carefully, as we will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

A. Alternative Treatments

1. Acupressure.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.
6. Adventure-based therapy, wilderness therapy, outdoor therapy, or similar programs.
7. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Integrative Health (NCCIH)* of the *National Institutes of Health*. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in *Section 1: Covered Health Care Services*.

B. Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all related expenses, including hospitalizations and anesthesia).

This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Care Services*.

The above exclusion of hospitalization and anesthesia expenses does not apply to dental-related services for which Benefits are provided as described under *Dental Services - Hospital and Alternate Facility Health Services Related to Dental Care* in *Section 1: Covered Health Care Services*.

This exclusion does not apply to dental care (oral exam, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Policy, limited to:

- Transplant preparation.
- Prior to the initiation of immunosuppressive drugs.
- The direct treatment of acute traumatic Injury, cancer or cleft lip/palate as described under *Treatment of Cleft Lip or Palate or Both* in *Section 1: Covered Health Care Services*.

Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of tooth decay or cavities resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth or gums. Examples include:

- Removal, restoration and replacement of teeth.
- Medical or surgical treatments of dental conditions.
- Services to improve dental clinical outcomes.

This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement or the *Health Resources and Services Administration (HRSA)* requirement. This exclusion also does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Care Services*.

3. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Care Services*.
4. Dental braces (orthodontics). This exclusion does not apply to cleft lip/palate - related dental services for which Benefits are provided as described under *Treatment of Cleft Lip or Palate or Both* in *Section 1: Covered Health Care Services*.
5. Treatment of congenitally missing, malpositioned or supernumerary teeth, even if part of a Congenital Anomaly.

C. Devices, Appliances and Prosthetics

1. Devices used as safety items or to help performance in sports-related activities.
2. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces. This exclusion does not apply to braces for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services*.
3. Cranial molding helmets and cranial banding except when used to avoid the need for surgery, and/or to facilitate a successful surgical outcome.

4. The following items are excluded, even if prescribed by a Physician:
 - Blood pressure cuff/monitor.
 - Enuresis alarm.
 - Non-wearable external defibrillator.
 - Trusses.
 - Ultrasonic nebulizers.
5. Devices and computers to help in communication and speech except for dedicated speech generating devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services*.
6. Oral appliances for snoring.
7. Repair or replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.
8. Diagnostic or monitoring equipment purchased for home use, unless otherwise described as a Covered Health Care Service.
9. Powered and non-powered exoskeleton devices.

D. Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill. For Benefit plans that include the *Outpatient Prescription Drug Rider*, Benefits for outpatient prescription drugs are provided as described under the *Outpatient Prescription Drug Rider*. This exclusion does not apply to contraceptive prescription drug products for women as required by the comprehensive guidelines supported by the *Health Resources and Services Administration*.
2. Self-administered or self-infused medications. This exclusion does not apply to medications which, due to their traits (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to hemophilia treatment centers contracted to dispense hemophilia factor medications directly to Covered Persons for self-infusion. For Benefit plans that include the *Outpatient Prescription Drug Rider*, Benefits for outpatient prescription drugs are provided as described under the *Outpatient Prescription Drug Rider*.
3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are: covered as described above under *Pharmaceutical Products - Outpatient* in *Section 1, Covered Healthcare Services* or required in an Emergency and used while in the Physician's office.
4. Over-the-counter drugs and treatments, except for contraceptive drugs without a prescription as provided under the *Outpatient Prescription Drug rider*.
5. Growth hormone therapy.

E. Experimental or Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Care Services*.

F. Foot Care

1. Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care if you have diabetes for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Care Services*.
2. Nail trimming, cutting, or debriding.
3. Hygienic and preventive maintenance foot care. Examples include:
 - Cleaning and soaking the feet.
 - Applying skin creams in order to maintain skin tone.

This exclusion does not apply to preventive foot care if you are at risk of neurological or vascular disease arising from diseases such as diabetes.

4. Treatment of flat feet.
5. Treatment of subluxation of the foot.
6. Shoes, except as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services*.
7. Shoe orthotics, except as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services*.
8. Shoe inserts, except as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services*.
9. Arch supports.

G. Gender Dysphoria

1. Cosmetic Procedures, including the following:
 - Abdominoplasty.
 - Blepharoplasty.
 - Breast enlargement, including augmentation mammoplasty and breast implants.
 - Body contouring, such as lipoplasty.
 - Brow lift.
 - Calf implants.
 - Cheek, chin, and nose implants.
 - Injection of fillers or neurotoxins.
 - Face lift, forehead lift, or neck tightening.
 - Facial bone remodeling for facial feminizations.
 - Hair removal.

- Hair transplantation.
- Lip augmentation.
- Lip reduction.
- Liposuction.
- Mastopexy.
- Pectoral implants for chest masculinization.
- Rhinoplasty.
- Skin resurfacing.
- Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's apple).
- Voice modification surgery.
- Voice lessons and voice therapy.

H. Medical Supplies and Equipment

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
 - Compression stockings. This exclusion does not apply to Benefits for compression stockings for the treatment of lymphedemas as described *under Lymphedema Services under Additional Benefits Required by Maryland Law in Section 1: Covered Health Care Services.*
 - Ace bandages.
 - Gauze and dressings.

This exclusion does not apply to:

 - Disposable supplies necessary for the effective use of DME or prosthetic devices for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies* and *Prosthetic Devices* in *Section 1: Covered Health Care Services.* This exception does not apply to supplies for the administration of medical food products.
 - Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Care Services.*
 - Disposable supplies for which Benefits are provided as described under *Home Health Care* and *Hospice Care* in *Section 1: Covered Health Care Services.*
 - Ostomy supplies for which Benefits are provided as described under *Ostomy and Urologic Supplies* in *Section 1: Covered Health Care Services.*
 - Urinary catheters and related urologic supplies for which Benefits are provided as described under *Urinary Catheters* in *Section 1: Covered Health Care Services.*
2. Tubings and masks except when used with DME as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services.*
3. Prescribed or non-prescribed publicly available devices, software applications and/or monitors that can be used for non-medical purposes.
4. Repair or replacement of DME or orthotics due to misuse, malicious damage or gross neglect or to replace lost or stolen items. This exclusion does not apply to Benefits for compression stockings for

the treatment of lymphedemas following a mastectomy and for lymphedema services as described under *Lymphedema Services under Additional Benefits Required by Maryland Law in Section 1: Covered Health Care Services*.

I. Mental Health Care and Substance-Related and Addictive Disorders

In addition to all other exclusions listed in this *Section 2: Exclusions and Limitations*, the exclusions listed directly below apply to services described under *Mental Health Care and Substance-Related and Addictive Disorders Services in Section 1: Covered Health Care Services*.

1. Services performed in connection with conditions not classified in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association*. Note: Conditions defined as Alcohol Misuse and Drug Misuse are covered regardless of whether such conditions are classified in the *Diagnostic and Statistical Manual of the American Psychiatric Association*. See *Section 9 - Defined Terms* for definitions of Alcohol Misuse and Drug Misuse.
2. Outside of an assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
3. Treatment for Mental Illnesses that in the professional judgment of health care providers are deemed untreatable or not Medically Necessary.
4. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.
5. Tuition or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act*.

J. Nutrition

1. Individual and group nutritional counseling, including non-specific disease nutritional education such as general good eating habits, calorie control or dietary preferences. This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement. This exclusion also does not apply to medical nutritional education services that are provided as part of treatment for a disease by appropriately licensed or registered health care professionals when both of the following are true:
 - Nutritional education is required for a disease in which patient self-management is a part of treatment.
 - There is a lack of knowledge regarding the disease which requires the help of a trained health professional.
2. Food of any kind infant formula, standard milk-based formula, and donor breast milk. This exclusion does not apply to Benefits which are provided as described under *Medical Foods or Amino Acid-Based Elemental Formula in Section 1: Covered Health Care Services*.
3. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements and electrolytes. This exclusion does not apply to Benefits which are provided as described under *Medical Foods or Amino Acid-Based Elemental Formula in Section 1: Covered Health Care Services*.

K. Personal Care, Comfort or Convenience

1. Television.

2. Telephone.
3. Beauty/barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
 - Air conditioners, air purifiers and filters and dehumidifiers.
 - Batteries and battery chargers.
 - Breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the *Health Resources and Services Administration (HRSA)* guidelines or *United States Preventive Services Task Force* recommendations.
 - Car seats.
 - Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners.
 - Exercise equipment.
 - Home modifications such as elevators, handrails and ramps.
 - Hot and cold compresses.
 - Hot tubs.
 - Humidifiers.
 - Jacuzzis.
 - Mattresses.
 - Medical alert systems.
 - Motorized beds.
 - Music devices.
 - Personal computers.
 - Pillows.
 - Power-operated vehicles.
 - Radios.
 - Saunas.
 - Stair lifts and stair glides.
 - Strollers.
 - Safety equipment.
 - Treadmills.
 - Vehicle modifications such as van lifts.
 - Video players.
 - Whirlpools.

L. Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 9: Defined Terms*. Examples include:
 - Pharmacological regimens, nutritional procedures or treatments.
 - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
 - Skin abrasion procedures performed as a treatment for acne.
 - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
 - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
 - Sclerotherapy treatment for spider veins.
 - Hair removal or replacement by any means. This exclusion does not apply to Benefits which are described under *Hair Prosthesis* under *Additional Benefits Required by Maryland Law in Section 1: Covered Health Care Services*.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the first breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.
3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, or flexibility.
5. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded. This exclusion does not apply to evidence-based weight loss services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.

M. Procedures and Treatments

1. Removal of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).
3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
4. Rehabilitation services and Manipulative Treatment to improve general physical conditions that are provided to reduce potential risk factors, where improvement is not expected, including routine, long-term or maintenance/preventive treatment.
5. Rehabilitation services for speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, or Congenital Anomaly. This exclusion does not apply to speech therapy services for which Benefits are provided as described under *Treatment of Cleft Lip or Palate or Both* or *Habilitative Services* under *Additional Benefits Required by Maryland Law in Section 1: Covered Health Care Services*.
6. Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or stroke.

7. Physiological treatments and procedures that result in the same therapeutic effects when performed on the same body region during the same visit or office encounter.
8. Biofeedback.
9. Services for non-surgical treatment of TMJ, whether the services are considered to be medical or dental in nature.
10. Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for you because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea. This exclusion does not apply to the diagnostic and surgical procedures involving bones or joints of the face, neck or head for which Benefits are provided as described under *Bones of the Face, Neck, and Head* under *Additional Benefits Required by Maryland Law in Section 1: Covered Health Care Services*.
11. Stand-alone multi-disciplinary tobacco cessation programs. These are programs that usually include health care providers specializing in tobacco cessation and may include a psychologist, social worker or other licensed or certified professionals. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings. Tobacco cessation products are covered if the *Outpatient Prescription Drug Rider* is purchased. This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement.
12. Breast reduction surgery except for coverage as required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.
13. Helicobacter pylori (*H. pylori*) serologic testing.
14. Intracellular micronutrient testing.

N. Providers

1. Services performed by a provider who is a family member by birth or marriage. Examples include but are not limited to a spouse, brother, sister, parent or child, or any service the provider may perform on himself or herself.
2. Services performed by a provider with your same legal address.
3. Services provided at a Freestanding Facility or diagnostic Hospital-based Facility without an order written by a Physician or other provider. Services which are self-directed to a Freestanding Facility or diagnostic Hospital-based Facility. Services ordered by a Physician or other provider who is an employee or representative of a Freestanding Facility or diagnostic Hospital-based Facility, when that Physician or other provider:
 - Has not been involved in your medical care prior to the service, and
 - Is not involved in your medical care after the service is received.

This exclusion does not apply to breast cancer screening.

O. Reproduction

1. The following infertility treatment-related services:
 - Cryo-preservation and other forms of preservation of reproductive materials. This exclusion does not apply to Benefits for in vitro fertilization procedures for which Benefits are provided as described under *In Vitro Fertilization* and *Standard Fertility Preservation Procedures*

under *Additional Benefits Required by Maryland Law in Section 1: Covered Health Care Services*.

- Long-term storage (greater than one year) of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue.
- Donor services.

2. The following services related to a Gestational Carrier or Surrogate:

- All costs related to reproductive techniques including:
 - ◆ Assisted Reproductive Technology (ART).
 - ◆ Artificial insemination.
 - ◆ Intrauterine insemination.
 - ◆ Obtaining and transferring embryo(s).

The exclusion for costs related to reproductive techniques does not apply when the Gestational Carrier or Surrogate is a Covered Person for whom Benefits are provided as described under *Infertility Services in Section 1: Covered Health Care Services*. This exclusion does not apply to Benefits for in vitro fertilization procedures for which Benefits are provided as described under *In Vitro Fertilization and Standard Fertility Preservation Procedures under Additional Benefits Required by Maryland Law in Section 1: Covered Health Care Services*.

- Health care services including:
 - ◆ Inpatient or outpatient prenatal care and/or preventive care.
 - ◆ Screenings and/or diagnostic testing.
 - ◆ Delivery and post-natal care.

The exclusion for the health care services listed above does not apply when the Gestational Carrier or Surrogate is a Covered Person.

- All fees including:
 - ◆ Screening, hiring and compensation of a Gestational Carrier or Surrogate including surrogacy agency fees.
 - ◆ Surrogate insurance premiums.
 - ◆ Travel or transportation fees.

3. Costs of donor eggs and donor sperm.

4. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue. This exclusion does not apply to Benefits for in vitro fertilization procedures for which Benefits are provided as described under *In Vitro Fertilization and Standard Fertility Preservation Procedures under Additional Benefits Required by Maryland Law in Section 1: Covered Health Care Services*.

5. The reversal of voluntary sterilization.

6. For Benefit plans that include the *Outpatient Prescription Drug Rider*, Benefits for outpatient contraceptive prescription drug products are provided as described under the *Outpatient Prescription Drug Rider*. In addition, Benefits for insertion or removal of any contraceptive drug or device and associated Medically Necessary examination when performed in a Physician's office are provided as described under *Physician's Office Services in Section 1: Covered Health Care*

Services. When these services are performed outside the Physician office, Benefits are provided in the same manner and at the same level as those for any other Covered Health Care Services described in *Section 1: Covered Health Care Services.*

P. Services Provided under another Plan

1. Health care services for when other coverage is required by federal, state or local law to be bought or provided through other arrangements. Examples include coverage required by workers' compensation, or similar legislation. However this exclusion does not apply to health services provided through the *Maryland Medical Assistance Program*, payments received through no-fault automobile insurance or to a hospital or other institution of the state or of a county or municipal corporation of the state, whether or not the hospital or other institution is deemed charitable.

If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.

2. Health care services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
3. Health care services during active military duty.

Q. Transplants

1. Health care services for organ and tissue transplants, except those described under *Transplantation Services* in *Section 1: Covered Health Care Services.*
2. Health care services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.)
3. Health care services for transplants involving animal organs.
4. Transplant services that are not performed at a Designated Facility. This exclusion does not apply to cornea transplants.

R. Travel

1. Health care services provided in a foreign country, unless required as Emergency Health Care Services.
2. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Care Services received from a Designated Provider may be paid back as determined by us. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in *Section 1: Covered Health Care Services.*

S. Types of Care

1. Multi-disciplinary pain management programs provided on an inpatient basis for sharp, sudden pain or for worsened long term pain.
2. Custodial Care or maintenance care.
3. Domiciliary care.
4. Private Duty Nursing.

5. Respite care.
6. Rest cures.
7. Services of personal care aides.
8. Work hardening (treatment programs designed to return a person to work or to prepare a person for specific work).

T. Vision and Hearing

1. Cost and fitting charge for eyeglasses and contact lenses.
2. Routine vision exams, including refractive exams to determine the need for vision correction.
3. Implantable lenses used only to fix a refractive error (such as *intacs* corneal implants).
4. Eye exercise or vision therapy.
5. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser and other refractive eye surgery.
6. Bone anchored hearing aids except when either of the following applies:
 - You have craniofacial anomalies whose abnormal or absent ear canals prevent the use of a wearable hearing aid.
 - You have hearing loss of sufficient severity that it would not be remedied enough by a wearable hearing aid or, for Enrolled Dependent children, when a wearable hearing aid would not be suitable to optimize audibility and listening skills in the environment commonly experienced by children.

More than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time you are enrolled under the Policy. However more than one bone anchored hearing aid is allowed for Enrolled Dependent children, when a wearable hearing aid would not be suitable to optimize audibility and listening skills in the environment commonly experienced by children and when such bone anchor hearing aids are prescribed, fitted, and dispensed by a licensed audiologist.

Repairs and/or replacement for a bone anchored hearing aid when you meet the above coverage criteria, other than for malfunctions.

U. All Other Exclusions

1. Health care services and supplies that do not meet the definition of a Covered Health Care Service. Covered Health Care Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:
 - Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
 - Medically Necessary.
 - Described as a Covered Health Care Service in this *Certificate* under *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*.
 - Not otherwise excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.
2. Physical, psychiatric or psychological exams, testing, all forms of vaccinations and immunizations or treatments when:

- Required only for school, sports or camp, travel, career or employment, insurance, marriage or adoption.
 - Related solely to judicial or administrative proceedings or orders. This exclusion does not apply to services that are determined to be Medically Necessary.
 - Conducted solely for purposes of medical research. This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Care Services*.
 - Required solely to get or maintain a license of any type.
3. Health care services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply if you are a civilian injured or otherwise affected by war, any act of war, or terrorism in non-war zones.
 4. Except as described below under *Extension of Coverage* in *Section 4: When Coverage Ends*, health care services received after the date your coverage under the Policy ends. This applies to all health care services, even if the health care service is required to treat a medical condition that started before the date your coverage under the Policy ended.
 5. Health care services when you have no legal responsibility to pay, or when a charge would not ordinarily be made in the absence of coverage under the Policy. This exclusion does not apply to: 1) reimbursement which may be required by us, payable to the *Department of Health and Mental Hygiene*, when such department has provided a benefit to a Covered Person for a service that is a Covered Health Service under this Policy; or 2) Medicaid.
 6. Charges in excess of the Allowed Amount or in excess of any specified limitation.
 7. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products. This exclusion does not apply to Benefits for in vitro fertilization procedures for which Benefits are provided as described under *In Vitro Fertilization and Standard Fertility Preservation Procedures* under *Additional Benefits Required by Maryland Law* in *Section 1: Covered Health Care Services*.
 8. Autopsy. This exclusion does not apply if we require an autopsy to be performed. In this case, we will cover the cost of the autopsy.
 9. Foreign language and sign language interpretation services offered by or required to be provided by a Network or out-of-Network provider.
 10. Health care services related to a non-Covered Health Care Service: This exclusion does not apply to services we would otherwise determine to be Covered Health Care Services if they are Medically Necessary ancillary services that would otherwise be covered under the Policy or are service treats complications that arise from the non-Covered Health Care Service.

For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure that requires hospitalization.
 11. Payment of any claim, bill, or other demand or request for payment for health care services that the appropriate regulatory board determines were provided as a result of a prohibited referral. "Prohibited referral" means a referral prohibited by 1-302 of the *Maryland Health Occupations Article*.

Section 3: When Coverage Begins

How Do You Enroll?

Eligible Persons must complete an enrollment form given to them by the Group. The Group will submit the completed forms to us, along with any required Premium. We will not provide Benefits for health care services that you receive before your effective date of coverage, except for the following instances:

- Enrollees who:
 - Are transitioning from the Maryland Medical Assistance Program and who are receiving behavioral health or dental benefits that were previously authorized by a third-party administrator.
 - Had Covered Health Care Services authorized by the previous carrier for:
 - ◆ the procedures, treatments, medications or services covered by the benefits offered by Us under your plan; and
 - ◆ the following time periods:
 - the lesser of the course of treatment or 90 days; and
 - the duration of the three trimesters of a pregnancy and the initial postpartum visit.

We may request a copy of the prior authorization from the previous carrier, which must be submitted to Us within 10 days after receipt of the request. After the above noted timeframes have lapsed, We may elect to perform our own utilization review in order to reassess and make Our own determination regarding the need for continued treatment and to authorize any continued procedure, treatment, medication or service determined to be medically necessary.

- Enrollees who have been receiving covered health care services from an Out-of-Network provider may continue to receive services from that provider as outline in the *Continuity of Care* provision in the *Schedule of Benefits*.

What If You Are Hospitalized When Your Coverage Begins?

We will pay Benefits for Covered Health Care Services when all of the following apply:

- You are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins.
- You receive Covered Health Care Services on or after your first day of coverage related to that Inpatient Stay.
- You receive Covered Health Care Services in accordance with the terms of the Policy.

These Benefits are subject to your previous carrier's obligations under state law or contract.

You should notify us of your hospitalization within 48 hours of the day your coverage begins, or as soon as reasonably possible. Network Benefits are available only if you receive Covered Health Care Services from Network providers.

Who Is Eligible for Coverage?

The Group determines who is eligible to enroll and who qualifies as a Dependent.

Eligible Person

Eligible Person usually refers to an employee or member of the Group who meets the eligibility rules. When an Eligible Person enrolls, we refer to that person as a Subscriber. For a complete definition of Eligible Person, Group and Subscriber, see *Section 9: Defined Terms*.

Eligible Persons must live or work within the Service Area.

If both spouses are Eligible Persons of the Group, each may enroll as a Subscriber or be covered as an Enrolled Dependent of the other, but not both.

Dependent

Dependent generally refers to the Subscriber's spouse and children. When a Dependent enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see *Section 9: Defined Terms*.

Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Policy.

If both parents of a Dependent child are enrolled as a Subscriber, only one parent may enroll the child as a Dependent.

When Do You Enroll and When Does Coverage Begin?

Except as described below, Eligible Persons may not enroll themselves or their Dependents.

Initial Enrollment Period

When the Group purchases coverage under the Policy from us, the Initial Enrollment Period is the first period of time when Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date shown in the Policy. We must receive the completed enrollment form within 31 days of the date the Eligible Person becomes eligible and any required Premium on the effective date.

Open Enrollment Period

The Group sets the Open Enrollment Period. During the Open Enrollment Period, Eligible Persons can enroll themselves and their Dependents.

During the Open Enrollment Period, Eligible Persons can:

- Enroll themselves and their Dependents.
- Discontinue enrollment in a health benefit plan offered by the Group; or
- Change enrollment in a health benefit plan offered by the Group to a different health benefit plan offered by the Group.

Coverage begins on the date identified by the Group. We must receive the completed enrollment form within 31 days of the date the Eligible Person becomes eligible and any required Premium on the effective date.

New Eligible Persons

Coverage for a new Eligible Person and his or her Dependents begins on the date agreed to by the Group. We must receive the completed enrollment form within 31 days of the date the Eligible Person becomes eligible and any required Premium on the effective date.

Adding New Dependents

Subscribers may enroll Dependents who join their family because of any of the following events:

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- Legal guardianship.
- Court or administrative order.
- Registering a Domestic Partner.

In addition, the following rules apply in accordance with state law:

- The newborn child of the Subscriber or the Subscriber's spouse is covered automatically from the moment of birth for at least 31 days.
- The newborn grandchild of the Subscriber or the Subscriber's spouse is covered automatically from the moment of birth for at least 31 days, if the newborn grandchild is a dependent of the Subscriber/Subscriber's spouse and is in the court-ordered custody of the Subscriber/Subscriber's spouse.
- The newly adopted child or grandchild of the Subscriber or the Subscriber's spouse is covered automatically from the date of adoption for at least 31 days. "Date of adoption" means the earlier of a judicial decree of adoption, or the assumption of custody, pending adoption, of a prospective adoptive child by a prospective adoptive parent.
- A newly eligible grandchild is covered automatically from the date the grandchild is placed in the court ordered custody of the Subscriber or the Subscriber's spouse.
- The child in the custody of the Subscriber or the Subscriber's spouse as a result of a guardianship of more than 12 months duration granted by a court or testamentary appointment is covered automatically from the date of such appointment for at least 31 days.

If payment of a specific Premium is required to provide coverage for any of the above, we will require notification and payment of the required Premium be furnished to us within 31 days after the birth, adoption, or date of court or testamentary appointment in order to have coverage continued beyond the 31 day period.

In addition, the following rules apply in accordance with state law for a court or an administrative order:

The child of a Subscriber for whom the court or the support enforcement agency has ordered the Subscriber to provide health care coverage is covered automatically from the date of the order. The Subscriber must pay any applicable Premium necessary to provide coverage for such child. When the Subscriber does not include the child in the enrollment, we will allow the non-subscribing parent, the support enforcement agency, or the *Department of Health and Mental Hygiene* to apply for the enrollment on behalf of the child and include the child in the coverage under the Policy.

For all other Dependents:

Coverage for all other Dependents begins on the date of the event. We must receive the completed enrollment form and any required Premium within 31 days of the event. If you fail to enroll your Dependent during the 31 day period, you will be able to enroll your Dependent during the next Open

Enrollment Period or under a special enrollment period, if applicable. See the *Open Enrollment Period* provision above and the *Special Enrollment Period* provision below.

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan ended for cause, or because premiums were not paid on a timely basis.

An Eligible Person and/or Dependent does not need to elect COBRA continuation coverage to preserve special enrollment rights. Special enrollment is available to an Eligible Person and/or Dependent even if COBRA is not elected.

A special enrollment period applies to an Eligible Person and any Dependents when one of the following events occurs:

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- Registering a Domestic Partner.
- Death of a spouse.
- Involuntary termination of a spouse's coverage under another plan.

With regard to the last two bullet points above, if the special enrollment period applies because prior coverage under another plan that ended due to the death or involuntary termination of a spouse, enrollment and payment of Premium for coverage under this plan must occur within six months of the date the prior coverage ended.

A special enrollment period also applies for an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period if any of the following are true:

- The Eligible Person previously declined coverage under the Policy, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date of determination of subsidy eligibility.
- The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period and coverage under the prior plan ended because of any of the following:
 - Loss of eligibility (including legal separation, divorce or death).
 - The employer stopped paying the contributions. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer.
 - In the case of COBRA continuation coverage, the coverage ended.
 - The Eligible Person and/or Dependent no longer resides, lives or works in an HMO service area if no other benefit option is available.
 - The plan no longer offers benefits to a class of individuals that includes the Eligible Person and/or Dependent.

- The Eligible Person and/or Dependent loses eligibility under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date coverage ended.

When an event takes place (for example, a birth, marriage or determination of eligibility for state subsidy), coverage begins on the date of the event. We must receive the completed enrollment form and any required Premium within 31 days of the event unless otherwise noted above.

For an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period because they had existing health coverage under another plan, the effective date of coverage will be the day following the day coverage under the prior plan ends. Except as otherwise noted above, coverage will only begin from the effective date if we receive the completed enrollment form and any required Premium within 31 days of the date coverage under the prior plan ended.

Section 4: When Coverage Ends

General Information about When Coverage Ends

As permitted by law, we may end the Policy and/or all similar benefit plans at any time for the reasons explained in the Policy.

Your right to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date, except as noted below under *Extension of Coverage*.

When your coverage ends, we will still pay claims for Covered Health Care Services that you received before the date your coverage ended. However, once your coverage ends, we will not pay claims for any health care services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended), except as noted below under *Extension of Coverage*.

Unless otherwise stated, an Enrolled Dependent's coverage ends on the date the Subscriber's coverage ends.

Please note that if you are subject to the *Extension of Coverage* provision later in this section, entitlement to Benefits ends as described in that section.

What Events End Your Coverage?

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

Your coverage ends on the date the Policy ends. In this event, the Group is responsible for notifying you that your coverage has ended.

- **The Subscriber No Longer Resides or Works within the Service Area**

The Subscriber or the Group must notify us if you move from, and no longer work in, the Service Area. When we are so notified, we will send you written notification of termination 30 days in advance of the termination date.

- **You Are No Longer Eligible**

Your coverage ends on the last day of the period for which the Premium has been paid during which you are no longer eligible to be a Subscriber or Enrolled Dependent. Please refer to *Section 9: Defined Terms* for definitions of the terms "Eligible Person," "Subscriber," "Dependent" and "Enrolled Dependent."

- **We Receive Notice to End Coverage**

Your coverage ends on the last day of the calendar month in which we receive the required notice from the Group to end your coverage, or on the date requested in the notice, if later. The Group is responsible for providing written notice to us to end your coverage.

- **Subscriber Retires or Is Pensioned**

Your coverage ends the last day of the period for which the Premium has been paid during which the Subscriber is retired or receiving benefits under the Group's pension or retirement plan. The Group is responsible for providing written notice to us to end your coverage.

Fraud or Intentional Misrepresentation of a Material Fact

We will provide 30 days advance required notice to the Subscriber that coverage will end on the date we identify in the notice because you committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include knowingly providing incorrect information relating to another person's eligibility or status as a Dependent. You may appeal this decision during the notice period. The notice will contain information on how to appeal the decision.

If we find that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact we have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Policy. Such Benefits payable to us will be reduced by the Premiums that were paid for your coverage during the time you were incorrectly covered.

After the Policy has been in effect for two years, it may not be terminated, except for non-payment of Premium.

Coverage for a Disabled Dependent Child

Coverage for an unmarried Enrolled Dependent child who is incapacitated will not end just because the child has reached a certain age. We will extend the coverage for that child beyond this age if both of the following are true:

- The Enrolled Dependent child is not able to support him/herself because of mental, developmental or physical incapacity that originated before the Enrolled Dependent child attained the limiting age.
- The Enrolled Dependent child depends mainly on the Subscriber, or another individual covered under this Policy, for support.

Coverage will continue as long as the Enrolled Dependent child is medically certified as incapacitated and dependent unless coverage otherwise ends in accordance with the terms of the Policy.

You must furnish us with proof of the medical certification of incapacity within 31 days of the date coverage would have ended because the child reached a certain age. Before we agree to this extension of coverage for the child, we may require that a Physician we choose examine the child. We will pay for that exam.

We may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical exams at our expense. We will not ask for this information more than once a year.

If you do not provide proof of the child's disability and dependency within 31 days of our request as described above, coverage for that child will end.

Extension of Coverage

A temporary extension of coverage will be given to a Covered Person who meets one or more of the following conditions on the date the Covered Person's coverage ends:

- The Covered Person is Totally Disabled.
- The Covered Person is undergoing treatment other than treatment for an accidental dental injury as described under *Dental Services - Accident Only* in *Section 1: Covered Health Care Services*.
- The Covered Person is in a Hospital.

The temporary extension will continue until (a) the day the Total Disability or treatment ends; or (b) 12 months from the date coverage under the Policy would otherwise have ended whichever occurs first. No Premium will be charged for this coverage extension.

With regard to an extension of coverage due to Total Disability, we may request proof of disability at any time.

With regard to the Covered Person undergoing dental treatment as part of an accidental injury as described under *Dental Services - Accident Only* in *Section 1: Covered Health Care Services*, the temporary extension will continue for a period of 90 days from the date coverage under the Policy would otherwise have ended if the dental treatment:(1) begins before the date coverage ends; and (2) requires two or more visits on separate days to the dentist's office.

Note: If the Covered Person becomes covered under another health plan on the date following the date coverage ends under this Policy and (1) the coverage provided by the new health benefit plan is provided at a cost to the individual that is less than or equal to the cost to the individual as the extended Benefit provided under this Policy and (2) the new coverage does not result in an interruption of benefits, this temporary extension of coverage does not apply.

Continuation of Coverage

If your coverage ends under the Policy, you may have the right to elect continuation coverage (coverage that continues on in some form) in accordance with federal or state law.

Continuation coverage under *COBRA* (the federal *Consolidated Omnibus Budget Reconciliation Act*) is available only to Groups that are subject to the terms of *COBRA*. Contact your plan administrator to find out if your Group is subject to the provisions of *COBRA*.

If you chose continuation coverage under a prior plan which was then replaced by coverage under the Policy, continuation coverage will end as scheduled under the prior plan or in accordance with federal or state law, whichever is earlier.

We are not the Group's designated "plan administrator" as that term is used in federal law, and we do not assume any responsibilities of a "plan administrator" according to federal law.

We are not obligated to provide continuation coverage to you if the Group or its plan administrator fails to perform its responsibilities under federal law. Examples of the responsibilities of the Group or its plan administrator are:

- Notifying you in a timely manner of the right to elect continuation coverage.
- Notifying us in a timely manner of your election of continuation coverage.

Continuation of Coverage under State Law for Surviving Spouses and Children

An Enrolled Dependent whose coverage under the Policy would otherwise end due to the death of the Subscriber is entitled to continue coverage as described in this section. This right to continue coverage also applies to a newborn child who is born to the Enrolled Dependent spouse after the date of the Subscriber's death. In order for an Enrolled Dependent to continue coverage, the Subscriber must have been continuously covered under the Policy (or a predecessor group policy with the same Group) for a period of at least 3 months prior to his or her death and the Enrolled Dependent spouse must have been continuously covered under the Policy (or a predecessor group policy with the same Group) for a period of at least 30 days prior to his or her death.

If the Enrolled Dependent spouse or child wishes to continue coverage, he or she must request that the Group provide an election notification form. Within 14 days of the receipt of the request, the Group will deliver or send by first-class mail an election notification form. Continuation coverage must be elected within 45 days of the date of the Subscriber's death and the Enrolled Dependent must make any required payment for coverage to the Group.

Continued coverage shall end on the earlier of the following dates:

- Eighteen (18) months after the date continuation coverage began;
- For a Dependent child, the date coverage would otherwise end as described in *Section 4: When Coverage Ends*;
- The date the Group ceases to provide Benefits to its employees under a group contract;
- The date coverage ends for failure to make timely payment of the Premium;
- The date the Covered Person becomes eligible to be insured under any other group health plan;
- The date the Covered Person becomes covered under any non-group insurance policy or contract;
- The date the Covered Person becomes entitled to benefits under Title XVIII of the Social Security Act; or
- The date the Covered Person elects to end coverage.

Continuation of Coverage under State Law for Divorced Spouses and Children

An Enrolled Dependent whose coverage under the Policy would otherwise end due to divorce from the Subscriber is entitled to continue coverage as described in this section. This right to continue coverage also applies to a newborn child who is born to the Enrolled Dependent spouse after the date that coverage would have otherwise end due to divorce.

If the Enrolled Dependent spouse or child wishes to continue coverage, he or she or the Subscriber must notify the Group of the divorce. This notification must be provided not later than described in (1) or (2) below.

- (1) 60 days after the applicable change in status if on the date of the change the Subscriber is covered under the Policy or under another group contract issued to the same Group. In this case coverage will be effective back to the date of the applicable change in status.
- (2) 30 days after the date the insured employee becomes eligible for coverage under a group contract issued to another employer, if the insured employee becomes covered under the new employer's group contract after the applicable change in status. In this case, coverage shall go back to the date of eligibility.

The Subscriber or the divorced spouse must make any required payment for coverage to the Group, either through payroll deduction or other mutually agreed upon method.

Continued coverage shall end on the earlier of the following dates:

- For a Dependent child, the date coverage would otherwise end as described in *Section 4: When Coverage Ends*;
- The date the Group ceases to provide Benefits to its employees under a group contract;
- The date the Covered Person becomes eligible to be insured for Hospital, medical, or surgical Benefits under any insured or self-insured group health Benefit program or plan that is written on an expense incurred basis or with a health maintenance organization;
- The date the Covered Person becomes covered under any Hospital, medical, or surgical coverage under a non-group contract or policy that is written on an expense incurred basis or with a health maintenance organization;
- The date the Covered Person becomes entitled to benefits under *Title XVIII of the Social Security Act*;
- For an Enrolled Dependent spouse, the date the Enrolled Dependent spouse remarries; or

- The date the Covered Person elects to end coverage. In order to terminate coverage, the Subscriber and Enrolled Dependent spouse must jointly sign a termination statement or the Subscriber must provide the Group with a signed and sworn affidavit verifying all facts in the termination statement.

Continuation of Coverage under State Law Due to the Subscriber's Voluntary or Involuntary Termination

Covered Persons whose coverage under the Policy would otherwise end due to the Subscriber's voluntary or involuntary termination from employment are entitled to continue coverage as described in this section. In order for a Covered Person to continue coverage, the Subscriber must have been continuously covered under the Policy (or a predecessor group policy with the same Group) for a period of at least 3 months prior to the voluntary or involuntary termination of employment and the Enrolled Dependent must have been covered under the Policy prior to the voluntary or involuntary termination of employment.

If a Covered Person wishes to continue coverage, he or she must request that the Group provide an election notification form. Within 14 days of the receipt of the request, the Group will deliver or send by first-class mail an election notification form. Continuation coverage must be elected within 45 days of the date of the voluntary or involuntary termination from employment and the Covered Person must make any required payment for coverage to the Group.

Continued coverage shall end on the earlier of the following dates:

- Eighteen (18) months after the date continuation coverage began;
- For a Dependent child, the date coverage would otherwise terminate as described in *Section 4: When Coverage Ends*;
- The date coverage ends for failure to make timely payment of the Premium;
- The date the Group ceases to provide Benefits to its employees under a group contract;
- The date the Covered Person becomes eligible to be insured under any other group health plan;
- The date the Covered Person becomes covered under any non-group insurance policy or contract;
- The date the Covered Person becomes entitled to benefits under *Title XVIII of the Social Security Act*;
- The date the Covered Person elects to end coverage.

Section 5: How to File a Claim

How Are Covered Health Care Services from Network Providers Paid?

We pay Network providers directly for your Covered Health Care Services. If a Network provider bills you for any Covered Health Care Service, contact us. However, you are required to meet any applicable deductible and to pay any required Co-payments and Co-insurance to a Network provider at the time of service, or when you receive a bill from the provider.

How Are Covered Health Care Services from an Out-of-Network Provider Paid?

When you receive Covered Health Care Services from an out-of-Network provider as a result of an Emergency, at an Urgent Care Center outside the Service Area, or if a Covered Health Care Service received by an out-of-Network provider was preauthorized or otherwise approved by us or a Network provider, or obtained pursuant to a verbal or written referral by us or a Network provider, we pay out-of-Network providers directly. However, if you have already paid the out-of-Network provider, we will accept a request for payment submitted by you. If you submit a request for payment, we do not require that you complete a claim form, however you must file the claim in a format that contains all of the information we require, as described below.

You have up to a year from the date of service to submit a request for payment of Benefits. Failure to furnish the request for payment within the time required does not invalidate or reduce a claim if it was not reasonably possible to submit the request within the required time and the claim is submitted within two years after the date of service. If you are legally incapacitated, the time frame for submitting a claim is suspended until legal capacity has been regained. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Providers have 180 days from the date a covered service is rendered to submit a claim for reimbursement.

Required Information

We do not require that you complete a claim form or that you provide a separate notice of claim prior to submitting your request for payment of Benefits; however when you request payment of Benefits from us, you must provide us with all of the following information:

- The Subscriber's name and address.
- The patient's name and age.
- The number stated on your ID card.
- The name and address of the provider of the service(s).
- The name and address of any ordering Physician.
- A diagnosis from the Physician.
- An itemized bill from your provider that includes the *Current Procedural Terminology* (CPT) codes or a description of each charge.
- The date the Injury or Sickness began.

- A statement indicating either that you are, or you are not, enrolled for coverage under any other health plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

The above information should be filed with us at the address on your ID card.

When filing a claim for Outpatient Prescription Drug Benefits, your claims should be submitted to:

Optum RX

PO Box 29077

Hot Springs, AR 71903

Payment of Benefits

We will pay Benefits within 30 days after we receive your request for payment that includes all required information.

You do not have the right to bring any legal proceeding or action against us within 60 days of the date you submit your request for payment as directed above or after the expiration of 3 years after the written proof of loss is required to be furnished.

In addition, if a child has coverage through an insuring parent, we will pay Benefits to the non-insuring parent, health care provider, or the *Department of Health and Mental Hygiene* if the non-insuring parent incurs expenses for the health care provided to the child.

Section 6: Questions, Complaints and Appeals

To resolve a question, complaint, or appeal, just follow these steps:

What if You Have a Question?

Call the telephone number shown on your ID card. Representatives are available to take your call during regular business hours, Monday through Friday.

What if You Have a Complaint?

Call the telephone number shown on your ID card. Representatives are available to take your call during regular business hours, Monday through Friday.

If you would rather send your complaint to us in writing, the representative can provide you with the address.

If the representative cannot resolve the issue over the phone, he/she can help you prepare and submit a written complaint. We will notify you of our decision regarding your complaint within 60 days of receiving it.

Adverse Decisions, Adverse Decision Grievances and Adverse Decision Complaints

Defined Terms

For the purpose of this Section, the following terms have the following meanings:

- "Adverse decision" is our determination that a proposed or delivered Covered Health Care Service which would otherwise be covered under the Policy is not or was not, Medically Necessary, appropriate or efficient, and may result in non-coverage of the health service but does not include a decision concerning a Subscriber's status as a Member.
- "Adverse decision complaint" is a protest filed with the Insurance Commissioner involving an adverse decision or grievance decision concerning a Covered Person.
- "Adverse decision grievance" means a protest by you, your representative, or your health care provider on your behalf with us through our internal grievance process regarding an adverse decision.
- "Compelling reason" means to show that a potential delay in receipt of a health care service until after the Covered Person or health care provider exhausts the internal grievance process and obtains a final decision under the grievance process could result in loss of life, serious impairment to a bodily function, serious dysfunction of a bodily organ, the Covered Person remaining seriously mentally ill or using intoxicating substances with symptoms that cause the Covered Person to be in danger to self or others or the Covered Person continuing to experience severe withdrawal symptoms. A Covered Person is considered to be in danger to self or others if the Covered Person is unable to function in activities of daily living or care for self without imminent dangerous consequences.
- "Complaint" is a protest filed with the Insurance Commissioner that is either; a) an adverse decision complaint, or b) a complaint as allowed under the provision entitled *Complaints* below.
- "Grievance decision" is a final determination by us that arises from an adverse decision grievance filed with us under our internal adverse decision grievance process regarding an adverse decision.

- "Health Advocacy Unit" means the *Health Education and Advocacy Unit* in the *Division of Consumer Protection of the Office of the Attorney General*.
- "Health care provider" means a Hospital, or an individual who is licensed or otherwise authorized in the State of Maryland to provide health care services in the ordinary course of working or practice of a profession and is a treating provider of a Covered Person.
- "Your representative" means an individual who has been authorized by you to file a grievance or a complaint on your behalf.

Notice Requirements

All notification requirements provided to you, your representative, and/or your health care provider as described in this Section will be provided in a culturally and linguistically appropriate manner.

Complaints

You, your representative, or your health care provider filing a complaint on your behalf, may file a complaint with the Commissioner without first filing an adverse decision grievance with us and receiving a grievance decision if:

- We waive the requirement that our internal grievance process be exhausted before filing a complaint with the Commissioner;
- We have failed to comply with any of the requirements of the internal grievance process as described in this section;
- You, your representative, or your health care provider provides sufficient information and supporting documentation in the complaint that demonstrates a compelling reason for the complaint; or
- Your complaint is based on one of the exceptions as described below under *Internal Adverse Decision Grievance Process*.

Internal Adverse Decision Grievance Process

Under the law, you must exhaust our internal adverse decision grievance process before you, your representative, or your health care provider file an adverse decision complaint with the Insurance Commissioner, unless the adverse decision involves an emergency case for which services have not already been rendered, or is described above under *Complaints*, or unless it is under one of the other circumstances outlined below. For retrospective denials (denials on health services which have already been rendered), a compelling reason may not be shown. If the adverse decision by us involves a compelling reason for which services have not been rendered, you, your representative or your health care provider may address your complaint directly to the Insurance Commissioner without first directing it to us.

Adverse Decisions

We will not make an adverse decision retrospectively regarding preauthorized or approved Covered Health Care Services delivered to a Covered Person, unless such preauthorization or approval was based on fraudulent, intentionally misrepresented, or omitted information. Such omitted information must have been critical requested information regarding the Covered Health Care Services whereby the preauthorization or approval for such Covered Health Care Services would not have been approved if the requested information had been received.

For non-Emergency cases, if we render an adverse decision, a notice of this adverse decision will be verbally communicated to you, your representative, or your health care provider.

We will document the adverse decision in writing after we have provided the verbal communication of the adverse decision as described above.

Written notification of the adverse decision will be sent to you, your representative, and your health care provider within five working days after the adverse decision has been made.

For Emergency case adverse decisions timeframes, see below under the provision entitled *Expedited Review in Emergency Cases*.

The adverse decision will be accompanied by a *Notice of Adverse Decision* attachment. This Notice will include the following information:

- Details concerning the specific factual basis for the denial in clear, understandable language;
- The specific criteria or guidelines on which the decision is based;
- The name, business address and direct telephone number of the medical director who made the decision;
- Written details of our internal adverse decision grievance process and procedures;
- The right for you, your representative, or your health care provider on your behalf, to file an adverse decision complaint with the Insurance Commissioner within four months of receipt of our adverse grievance decision;
- The right for you, your representative, or your health care provider on your behalf, to file an adverse decision complaint with the Insurance Commissioner without first filing an adverse decision grievance with us if you, your representative, or your health care provider acting on your behalf can demonstrate a compelling reason to do so.
- The Insurance Commissioner's address, telephone number and fax number; and
- The information shown below regarding assistance from the Health Advocacy Unit.

Adverse Decision Grievances

If you have received an adverse decision, you, your representative, or your health care provider on your behalf, have the right to file an adverse decision grievance with us. The following conditions apply to adverse decision grievance filings:

- The adverse decision grievance must be filed by you, your representative, or your health care provider on your behalf, with us within 60 days of receipt of our adverse decision letter unless the adverse decision is a retrospective denial in which case you have up to 180 days from the date of receipt to file an adverse decision grievance.
- For prospective denials (denials on health services that have not yet been rendered), we will render a grievance decision in writing within 30 working days after the filing date, unless it involves an emergency case as explained below. The "filing date" is the earlier of five days after the date the adverse decision grievance was mailed or the date of receipt. Unless written permission has been given per the fourth bulleted item below, you, your representative, or your health care provider on your behalf, have the right to file an adverse decision complaint with the Insurance Commissioner, if you have not received our grievance decision on or before the 30th working day after the filing date.
- For retrospective denials (denials on health services that have already been rendered), we will render a grievance decision within 45 working days after the filing date. Unless written permission has been given per the fourth bulleted item below, you, your representative, or your health care provider on your behalf, have the right to file an adverse decision complaint with the Insurance

Commissioner (see below), if you have not received our grievance decision on or before the 45th working day after the filing date.

- With written permission from you, your representative, or your health care provider on your behalf, the time frame within which we must respond can be extended up to an additional 30 working days.
- If we need additional information in order to review the case, we will notify you, your representative and/or your health care provider within five working days after the filing date. We will assist you, your representative, or the health care provider in gathering the necessary medical records without further delay. If no additional information is available or is not submitted to us, we will render a decision based on the available information.
- Except as described under the first two bullets in the *Complaints* provision above, for retrospective denials, you, your representative, or your health care provider on your behalf, must file an adverse decision grievance with us before filing an adverse decision complaint with the Insurance Commissioner, as described below.
- Notice of our grievance decision will be verbally communicated to you, your representative, or your health care provider. Written notification of our grievance decision will be sent to you, your representative and any health care provider who filed an adverse decision grievance on your behalf within five working days after the grievance decision has been made. If we uphold the adverse determination, the denial notification will include a *Notice of Grievance Decision*. This Notice will include the information in the bulleted items under Adverse Decision above.
- If any new or additional evidence is relied upon or generated by us during the determination of the adverse decision grievance, we will provide it to you free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.
- In addition to the first two bullet points in the Complaints provision above, for prospective denials, you, your representative, or your health care provider on your behalf, may file an adverse decision complaint with the Insurance Commissioner (see below) without first filing an adverse decision grievance with us, if you, your representative, or your health care provider can demonstrate that the adverse decision concerns a Compelling Reason.

Expedited Review in Emergency Cases

In emergency cases, you, your representative or your health care provider on your behalf may request an expedited review of an adverse decision. An "emergency case" is a case involving an adverse decision of proposed health services which are necessary to treat a condition or illness that, without immediate medical attention, would seriously jeopardize the life or health of the Covered Person or his or her ability to regain maximum function, or would cause the Covered Person to be in danger to self or others, or cause the Covered Person to continue using intoxicating substances in an imminently dangerous manner.

The procedure listed below will be followed:

- If the health care provider filed the adverse decision grievance, he or she will determine whether the basis for an emergency case or expedited review exists. If the Covered Person, or the Covered Person's representative, filed the adverse decision grievance, we, in consultation with the health care provider, will determine whether the basis for an emergency case or expedited review exists. In either case, the determination will be based on the above definition of "emergency case".
- We will render a verbal grievance decision to an adverse decision grievance filed by you, your representative, or your health care provider on your behalf, within 24 hours of receipt of the adverse decision grievance. Within one day after the verbal grievance decision has been communicated, we will send notice in writing of any adverse decision grievance to you, your representative, and if applicable, your health care provider. If we need additional information in order to review the case, we will verbally inform you, your representative and/or your health care provider, and will assist with procuring the additional information. If we do not render a grievance

decision within 24 hours, you, your representative, or your health care provider may file an adverse decision complaint directly with the Insurance Commissioner. If we uphold our decision to deny coverage for the Covered Health Care Services, we will send you, your representative and/or your health care provider the grievance decision in writing within one day of the verbal notification. The *Notice of Grievance Decision* will include the information specified for the *Notice of Adverse Decision* above.

Assistance From the Health Education and Advocacy Unit

The Health Advocacy Unit is available to assist you or your representative with filing an adverse decision grievance under our internal adverse decision grievance process and assist you or your representative in mediating a resolution of our adverse decision.

The Health Advocacy Unit is available to assist you or your representative in filing a complaint with the Insurance Commissioner.

NOTE: The Health Advocacy Unit is not available to represent or accompany you or your representative during the proceedings. The Health Advocacy Unit may be reached at:

Health Education and Advocacy Unit

Consumer Protection Division

Office of the Attorney General

200 St. Paul Place, 16th Floor

Baltimore, Maryland 21202

410-528-1840 or 1-877-261-8807 (toll free)

Fax number: 410-576-6571

E-mail: consumer@oag.state.md.us

Medical Directors

Our medical directors who are responsible for adverse decisions and grievance decisions may be reached at:

UnitedHealthcare of the Mid-Atlantic, Inc.

800 King Farm Boulevard

Rockville, Maryland 20850

301-762-8205/ 1-800-544-2853

Adverse Decision Complaints to the Insurance Commissioner

Within four months after receiving our *Notice of Grievance Decision*, or under the circumstances described above, you, your representative or your health care provider on your behalf, may submit an adverse decision complaint to the *Insurance Commissioner* at:

Maryland Insurance Administration

Appeals and Grievance Unit

200 St. Paul Place, Suite 2700

Baltimore, Maryland 21202

1-800-492-6116 or 410-468-2000

Fax Number 410-468-2270

When filing a complaint with the *Insurance Commissioner*, you or your representative will be required to authorize the release of any medical records of the Covered Person that may be required to be reviewed for the purpose of reaching a decision on the complaint.

The *Health Advocacy Unit* is available to assist you or your representative in filing a complaint with the *Insurance Commissioner*.

Health Education and Advocacy Unit

200 St. Paul Place, 16th Floor

Baltimore, Maryland 21202

Telephone number: (410) 528-1840

Fax number: (410) 576-6571

E-mail: consumer@oag.state.md.us

The *Insurance Commissioner* will make a final decision on a complaint as follows:

- For an emergency case, written notice of the *Insurance Commissioner's* final decision will be sent to the Covered Person, the Covered Person's representative and/or the health care provider within one day after the *Insurance Commissioner* has given verbal notification of the final decision.
- For an adverse decision complaint involving a pending health service, written notice of the *Insurance Commissioner's* final decision will be sent to the Covered Person, the Covered Person's representative and/or the health care provider within 45 days after the adverse decision complaint is filed.
- For an adverse decision complaint involving a retrospective denial of health services already provided, written notice of the *Insurance Commissioner's* final decision will be sent to the Covered Person, the Covered Person's representative and/or the health care provider within 45 days after the adverse decision complaint is filed.

Except for emergency cases, the time periods above for notification may be extended if additional information is necessary in order for the *Insurance Commissioner* to render a final decision, or if it is necessary to give priority to adverse decision complaints regarding pending health services.

Assistance from State Agencies

Governmental agencies are available to assist you with complaints that are not a result of an adverse decision as described above.

For quality of care issues and health care insurance complaints, contact the *Consumer Complaint & Investigation* at:

Consumer Complaint & Investigation

Life and Health

Maryland Insurance Administration

200 St. Paul Place, Suite 2700

Baltimore, Maryland 21202

Telephone number: 1-800-492-6116

Fax number: (410) 468-2270 or (410) 468-2260

For assistance in resolving a billing or payment dispute with the Company or a provider, contact the Health Advocacy Unit at:

Office of the Attorney General

Health Education and Advocacy Unit

200 St. Paul Place, 16th Floor

Baltimore, Maryland 21202

Telephone number: (410) 528-1840

Fax number: (410) 576-6571

E-mail: consumer@oag.state.md.us

Coverage and Appeal Decisions

For the purpose of this section, the following terms have the following meanings:

- "Appeal" means a protest filed by a Covered Person, a Covered Person's representative or a health care provider with us under our internal appeal process regarding a coverage decision concerning a Covered Person.
- "Appeal decision" means a final determination made by us that arises from an appeal filed with us under our appeal process regarding a coverage decision concerning a Covered person.
- "Coverage decision" means:
 - an initial determination by us or our representative that results in non-coverage of a health care service;
 - a determination by us that an individual is not eligible for coverage under the Policy;
 - any determination by us that results in the rescission of an individual's coverage under the Policy.

A coverage decision includes a nonpayment of all or any part of a claim.

A coverage decision does not include:

- ♦ an adverse decision as described above; or
- ♦ a pharmacy inquiry.
- "Health Advocacy Unit" means the *Health Education and Advocacy Unit* in the *Division of Consumer Protection of the Office of the Attorney General*.
- "Pharmacy inquiry" means an inquiry submitted by a pharmacist or pharmacy on behalf of a Covered Person to us or a pharmacy benefits manager at the point of sale about the scope of pharmacy coverage, pharmacy benefit design, or formulary, if available, under the Policy.
- "Urgent medical condition" means a condition that satisfies either of the following:
 - A medical condition, including a physical condition, a mental condition, or a dental condition, where the absence of medical attention within 72 hours could reasonably be expected by an individual, acting on our behalf, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, to result in:

- ◆ Placing the Covered Person's life or health in serious jeopardy;
 - ◆ The inability of the Covered Person to regain maximum function;
 - ◆ Serious impairment to bodily function;
 - ◆ Serious dysfunction of any bodily organ or part; or
 - ◆ The Covered Person remaining seriously mentally ill with symptoms that cause the Covered Person to be a danger to self or others.
- "Your representative" means an individual who has been authorized by you to file an appeal or a complaint on your behalf.

Within 30 calendar days after a coverage decision has been made, we will send a written notice of the coverage decision to you, your representative (if any) and your treating health care provider. Notice of the coverage decision will include the following:

- Details, in clear, understandable language, the specific factual basis for the decision;
- The right for you, your representative, or a health care provider acting on your behalf to file an appeal with us;
- The right for you, your representative, or a health care provider acting on your behalf to file a complaint with the Insurance Commissioner without first filing an appeal with us, if the coverage decision involves an urgent medical condition for which care has not been rendered;
- The Insurance Commissioner's address, telephone number and fax number;
- An explanation that the Health Advocacy Unit is available to assist you or your representative in both mediating and filing an appeal under our internal appeal process; and
- The address, telephone number, facsimile number and electronic mail address of the Health Advocacy Unit.

If a coverage decision results in non-coverage of a health care service including non-payment of all or any part of your claim, you, your representative, or your health care provider acting on your behalf, have a right to file an appeal within one hundred eighty (180) calendar days of receipt of the coverage decision. The appeal may be submitted verbally or in writing and should include any information you, your representative or a health care provider acting on your behalf believe will help us review your appeal. You, your representative or a health care provider acting on your behalf may call the phone number listed on your identification card to verbally submit your appeal. Send the written appeal to: Customer Support Group, P.O. Box 933, Frederick, MD 21705. We will render a final decision in writing to you, your representative and your health care provider acting on your behalf within 60 working days after the date on which the appeal is filed. Within thirty (30) calendar days after the appeal decision has been made, we will send you, your representative and your health care provider acting on your behalf, a written notice of the appeal decision.

Notice of an appeal decision will include the following:

- Details concerning the specific factual basis for the decision in clear, understandable language;
- The right for you, your representative, or a health care provider acting on your behalf, to file a complaint with the *Insurance Commissioner* within four months of receipt of our appeal decision;
- The *Insurance Commissioner's* address, telephone number and fax number;
- A statement that the Health Advocacy Unit is available to assist you in filing a complaint with the Commissioner; and
- The information shown below regarding assistance from the Health Advocacy Unit.

If you are dissatisfied with the outcome of the appeal, you, your representative or a health care provider acting on your behalf may file a complaint with the *Life and Health Complaint Unit, Maryland Insurance Administration, within four months after receipt of the appeal decision*. You, your representative or a health care provider acting on your behalf may contact the Life and Health Complaint Unit, Maryland Insurance Administration, at 200 St. Paul Place, Suite 2700, Baltimore, MD 21202, phone (410) 468-2000, toll free (800) 492-6116 or facsimile (410) 468-2260.

The *Insurance Commissioner* may request that you, your representative or a health care provider acting on your behalf whom filed the complaint, to sign a consent form authorizing the release of your medical records to the *Insurance Commissioner* or the Insurance Commissioner's designee that are needed in order to make a final decision on the complaint.

You, your representative, or a health care provider acting on your behalf may contact the Health Advocacy Unit at:

Health Education Advocacy Unit

Consumer Protection Division

Office of the Attorney General

200 St. Paul Place, 16th Floor

Baltimore, MD 21202

Telephone: 410/528-1840 or toll free at 1-877/261-8807; Fax#: 410/576-6571

Website address: www.oag.state.md.us

The *Health Advocacy Unit* can help you, your representative or a health care provider acting on your behalf prepare an appeal to file under our internal appeal procedure. That unit can also attempt to mediate a resolution to your dispute. The *Health Advocacy Unit* is not available to represent or accompany you or your representative during any proceeding of the internal appeal process.

Additionally, you, your representative or a health care provider acting on your behalf may file a complaint with the *Life and Health Complaint Unit, Maryland Insurance Administration*, without having to first file an appeal with us if (1) we have denied authorization for a health service not yet provided to you, and (2) you or the health care provider gives sufficient information and supporting documentation in the complaint that demonstrates an urgent medical condition exists.

Section 7: Coordination of Benefits

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Policy will be coordinated with those of any other plan that provides benefits to you. The language in this section is from model laws drafted by the *National Association of Insurance Commissioners (NAIC)* and represents standard industry practice for coordinating benefits.

When Does Coordination of Benefits Apply?

This *Coordination of Benefits (COB)* provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules below govern the order in which each Plan will pay a claim for benefits.

- **Primary Plan.** The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses.
- **Secondary Plan.** The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense. Allowable Expense is defined below.

Definitions

For purposes of this section, terms are defined as follows:

- A. **Plan.** A Plan is any of the following that provides benefits or services for medical, pharmacy or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
1. Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.
 2. Plan does not include: hospital indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; intensive care policies; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; medical benefits under group or individual automobile contracts or coverage under other federal governmental plans, unless permitted by law.

For purposes of this section, "intensive care policy" means a health insurance policy that provides benefits only when treatment is received in that specifically designated facility of a Hospital that provides the highest level of care and which is restricted to those patients who are physically, critically ill or injured.

Each contract for coverage under 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

- B. **This Plan.** This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.
- C. **Order of Benefit Determination Rules.** The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.
- D. **Allowable Expense.** Allowable Expense is a health care expense, including deductibles, co-insurance and co-payments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or according to contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense.

The following are examples of expenses or services that are not Allowable Expenses:

1. The difference between the cost of a semi-private hospital room and a private room is not an Allowable Expense unless one of the Plans provides coverage for private hospital room expenses.
 2. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
 3. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
 4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.
 5. The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions and preferred provider arrangements.
- E. **Closed Panel Plan.** Closed Panel Plan is a Plan that provides health care benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.
- F. **Custodial Parent.** Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

What Are the Rules for Determining the Order of Benefit Payments?

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

- A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.
- B. Except as provided in the next paragraph, a Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary unless the provisions of both Plans state that the complying plan is primary.

Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that this supplementary coverage shall be in excess of any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

- C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.
- D. Each Plan determines its order of benefits using the first of the following rules that apply:
 - 1. **Non-Dependent or Dependent.** The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.
 - 2. **Dependent Child Covered Under More Than One Coverage Plan.** Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:
 - a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
 - (1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
 - (2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.
 - b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:
 - (1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary Plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

- (2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.
- (3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.
- (4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - (a) The Plan covering the Custodial Parent.
 - (b) The Plan covering the Custodial Parent's spouse.
 - (c) The Plan covering the non-Custodial Parent.
 - (d) The Plan covering the non-Custodial Parent's spouse.
- c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.
- d) (i) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in paragraph (5) applies.
 - (ii) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in subparagraph (a) to the dependent child's parent(s) and the dependent's spouse.
- 3. **Active Employee or Retired or Laid-off Employee.** The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.
- 4. **COBRA or State Continuation Coverage.** If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.
- 5. **Longer or Shorter Length of Coverage.** The Plan that covered the person the longer period of time is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.
- 6. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of This Plan

- A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.
- B. If a Covered Person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts we need from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits.

We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give us any facts we need to apply those rules and determine benefits payable. If you do not provide us the information we need to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Payments Made

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, we may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Does This Plan Have the Right of Recovery?

If the amount of the payments we made is more than we should have paid under this COB provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or services provided for you. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Section 8: General Legal Provisions

What Is Your Relationship with Us?

It is important for you to understand our role with respect to the Group's Policy and how it may affect you. We help finance or administer the Group's Policy in which you are enrolled. We do not provide medical services or make treatment decisions. This means:

- We communicate to you decisions about whether the Group's Policy will cover or pay for the health care that you may receive. The Policy pays for Covered Health Care Services, which are more fully described in this *Certificate*.
- The Policy may not pay for all treatments you or your Physician may believe are needed. If the Policy does not pay, you will be responsible for the cost of any services that are not Covered Health Care Services.

We may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. We will use individually identifiable information about you as permitted or required by law, including in our operations and in our research. We will use de-identified data for commercial purposes including research.

Please refer to our *Notice of Privacy Practices* for details.

What Is Our Relationship with Providers and Groups?

We have agreements in place that govern the relationship between us, our Groups and Network providers, some of which are affiliated providers. Network providers enter into agreements with us to provide Covered Health Care Services to Covered Persons.

We do not provide health care services or supplies, or practice medicine. We arrange for health care providers to participate in a Network and we pay Benefits. Network providers are independent practitioners who run their own offices and facilities. Our credentialing process confirms public information about the providers' licenses and other credentials. It does not assure the quality of the services provided. We are not responsible for any act or omission of any provider.

We are not considered to be an employer for any purpose with respect to the administration or provision of benefits under the Group's Policy. We are not responsible for fulfilling any duties or obligations of an employer with respect to the Group's Policy.

The Group is solely responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of the Policy Charge to us.
- Notifying you of when the Policy ends.

When the Group purchases the Policy to provide coverage under a benefit plan governed by the *Employee Retirement Income Security Act* ("ERISA"), 29 U.S.C. §1001 et seq., we are not the plan administrator or named fiduciary of the benefit plan, as those terms are used in ERISA. If you have questions about your welfare benefit plan, you should contact the Group. If you have any questions about this statement or about your rights under ERISA, contact the nearest area office of the *Employee Benefits Security Administration, U. S. Department of Labor*.

What Is Your Relationship with Providers and Groups?

The relationship between you and any provider is that of provider and patient.

You are responsible for all of the following:

- Choosing your own provider.
- Paying, directly to your provider, Co-payments, Co-insurance and any deductible.
- Paying, directly to your provider, the cost of any non-Covered Health Care Service.
- Deciding if any provider treating you is right for you. This includes Network providers you choose and providers that they refer.
- Deciding with your provider what care you should receive.

Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and the Group is that of employer and employee, Dependent or other classification as defined in the Policy.

Notice

When we provide written notice regarding administration of the Policy to an authorized representative of the Group, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Group is responsible for giving notice to you.

Statements by Group or Subscriber

All statements made by the Group or by a Subscriber shall, in the absence of fraud, be deemed representations and not warranties. We will not use any statement made by the Group to void the Policy after it has been in force for two years. Once the Policy has been in effect for two years, it may not be terminated, except for non-payment of Premium.

A statement made by any Covered Person under the Policy relating to insurability may not be used in contesting the validity of the insurance with respect to which the statement was made after the insurance has been in force before the contest for a period of two years during the Covered Person's lifetime.

No statement will be used to void or reduce coverage under this Policy unless:

- The statement is contained in a written instrument signed by the Group or the Subscriber, and
- A copy of the statement is given to the Group, Subscriber or beneficiary of the Subscriber.

Do We Pay Incentives to Providers?

We pay Network providers through various types of contractual arrangements. Some of these arrangements may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction and/or cost-effectiveness.
- Capitation - a group of Network providers receives a monthly payment from us for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of

providing or arranging to provide the Covered Person's health care is less than or more than the payment.

- Bundled payments - certain Network providers receive a bundled payment for a group of Covered Health Care Services for a particular procedure or medical condition. Your Co-payment and/or Co-insurance will be calculated based on the provider type that received the bundled payment. The Network providers receive these bundled payments regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment. If you receive follow-up services related to a procedure where a bundled payment is made, an additional Co-payment and/or Co-insurance may not be required if such follow-up services are included in the bundled payment. You may receive some Covered Health Care Services that are not considered part of the inclusive bundled payment and those Covered Health Care Services would be subject to the applicable Co-payment and/or Co-insurance as described in your *Schedule of Benefits*.

We use various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with us includes any financial incentives, we encourage you to discuss those questions with your provider. You may also call us at the telephone number on your ID card. We can advise whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

Who Interprets Benefits and Other Provisions under the Policy?

We have the final authority to do all of the following:

- Interpret Benefits under the Policy.
- Interpret the other terms, conditions, limitations and exclusions set out in the Policy, including this *Certificate*, the *Schedule of Benefits* and any Riders and/or Amendments.
- Make factual determinations related to the Policy and its Benefits.

We may assign this authority to other persons or entities that provide services in regard to the administration of the Policy.

In certain circumstances, for purposes of overall cost savings or efficiency, we may offer Benefits for services that would otherwise not be Covered Health Care Services. The fact that we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.

Who Provides Administrative Services?

We provide administrative services or, as we determine, we may arrange for various persons or entities to provide administrative services, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time as we determine. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Amendments to the Policy

To the extent permitted by law, we have the right, as we determine and without your approval, to change, interpret, withdraw or add Benefits or end the Policy.

Any provision of the Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which the Policy is delivered) is amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to the Policy unless it is made by an Amendment or Rider which has been signed by one of our officers and consistent with applicable notice requirements. All of the following conditions apply:

- Amendments and Riders to the Policy are effective upon the Group's next anniversary date, except as otherwise permitted by law.
- No agent has the authority to change the Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to the Policy.

How Do We Use Information and Records?

We may use your individually identifiable health information as follows:

- To administer the Policy and pay claims.
- To identify procedures, products, or services that you may find valuable.
- As otherwise permitted or required by law.

We may request additional information from you to decide your claim for Benefits. We will keep this information confidential. We may also use de-identified data for commercial purposes, including research, as permitted by law. More detail about how we may use or disclose your information is found in our *Notice of Privacy Practices*.

By accepting Benefits under the Policy, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to the services provided to you. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form. We agree that such information and records will be considered confidential.

We have the right to release records concerning health care services when any of the following apply:

- Needed to put in place and administer the terms of the Policy.
- Needed for medical review or quality assessment.
- Required by law or regulation.

During and after the term of the Policy, we and our related entities may use and transfer the information gathered under the Policy in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to our *Notice of Privacy Practices*.

For complete listings of your medical records or billing statements you may contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, we will designate other persons or entities to request records or information from or related to you, and to release those records as needed. Our designees have the same rights to this information as we have.

Do We Require Examination of Covered Persons?

In the event of a question or dispute regarding your right to Benefits, we may require that a Network Physician of our choice examine you at our expense.

Is Workers' Compensation Affected?

Benefits provided under the Policy do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Subrogation and Reimbursement

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. We shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type, for any actual payments made by us for services and benefits provided by us to any Covered Person as a result of the occurrence that gave rise to a cause of action in which the Covered Person has recovered for medical expenses from: (i) third parties, including any person alleged to have caused the Covered Person to suffer injuries or damages; (ii) the employer of the Covered Person or (iii) any person or entity obligated to provide benefits or payments to Covered Persons, including benefits or payments for underinsured or uninsured motorist protection (these third parties and persons or entities are collectively referred to as "Third Parties"); provided, however, that we will not seek to recover payments made to a Covered Person under a personal injury protection policy. The Covered Person agrees to assign to us all rights of recovery against Third Parties, to the extent of the actual payments made us for the services and benefits that we provided.

The Covered Person shall cooperate with us in protecting our legal rights to subrogation and reimbursement. The Covered Person shall do nothing to prejudice our rights under this provision, either before or after the need for services or benefits under the Policy. We may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including filing suit in the name of the Covered Person. For the actual payments made by us for services provided under the Policy, we may collect, at our option, amounts from the proceeds of any settlement (whether before or after any determination of liability) or judgment that may be recovered by the Covered Person or his or her legal representative, regardless of whether or not the Covered Person has been fully compensated. Any proceeds of settlement or judgment shall be held in trust by the Covered Person for our benefit under these subrogation provisions.

Proceeds received by us will be reduced by a pro rata share of the court costs and legal fees incurred by the Covered Person applicable to the portion of the settlement returned to us. The Covered Person agrees to execute and deliver such documents (including a written confirmation of assignment, and consents to release medical records), and provide such help (including responding to requests for information about any accident or injuries and making court appearances) as we may reasonably request.

When Do We Receive Refunds of Overpayments?

If we pay Benefits for expenses incurred on your account, you, or any other person or organization that was paid, must make a refund to us if any of the following apply:

- All or some of the expenses were not paid or did not legally have to be paid by you. Such refund is not required if the Benefits were paid under Medicaid or for the treatment of tuberculosis, Mental Illness, or another illness covered under the Policy that is received in a Hospital or other institution of the state or of a county or municipal corporation of the state, whether or not the Hospital or other institution is deemed charitable.
- All or some of the payment we made exceeded the Benefits under the Policy.
- All or some of the payment was made in error.

The refund equals the amount we paid in excess of the amount we should have paid under the Policy. If the refund is due from another person or organization, you agree to help us get the refund when requested.

If the refund is due from the Covered Person and the Covered Person does not promptly refund the full amount, we may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Benefits for the Covered Person that are payable under the Policy. If a person or organization other than the Covered Person has received an overpayment and thus owes a refund, we may pursue any and all legally available means to recover such overpayment. The recovery of an overpayment from a person or organization other than the Covered Person through those means shall not render the Covered Person responsible to make any additional refund to us or to a provider that the Covered Person did not otherwise owe.

Is There a Limitation of Action?

You cannot bring any legal action against us to recover reimbursement until 60 days after you have properly submitted a request for reimbursement as described in *Section 5: How to File a Claim*. If you want to bring a legal action against us you must do so within three years of the date written proof of loss is required to be furnished or you lose any rights to bring such an action against us.

Is There a Liability for Reimbursement?

If for any reason beyond our control we are unable to provide the Covered Health Care Services described in this *Certificate*, we will reimburse any expenses you incur in obtaining the Covered Health Care Services through other providers, to the extent prescribed by the Insurance Commissioner of Maryland.

What Is the Entire Policy?

The Policy, this *Certificate*, the *Schedule of Benefits*, the Group's *Application* and any Riders and/or Amendments, make up the entire Policy that is issued to the Group. A change in the Policy is not valid:

- Until approved by an executive officer of the company, and
- Unless the approval is endorsed on the Policy or attached to the Policy.

Section 9: Defined Terms

Alcohol Misuse - unlawful use of alcohol, alcohol abuse or alcohol dependence. Alcohol abuse is a disease that is characterized by a pattern of pathological use of alcohol with repeated attempts to control its use, and with significant negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social. Alcohol dependence is a disease characterized by alcohol abuse and physical symptoms of withdrawal or tolerance.

Allowed Amounts - for Covered Health Care Services, incurred while the Policy is in effect, or while the Covered person is receiving Benefits under the *Extension of Coverage* provision in *Section 4: When Coverage Ends*, Allowed Amounts are determined by us as shown in the *Schedule of Benefits*.

Allowed Amounts are determined solely in accordance with our reimbursement policy guidelines. We develop these guidelines, as we determine, after review of all provider billings in accordance with one or more of the following methodologies:

- As shown in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that we accept.

Alternate Facility - a health care facility that is not a Hospital. It provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Care Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

It may also provide Mental Health Care Services or Substance-Related and Addictive Disorders Services on an outpatient or inpatient basis.

Amendment - any attached written description of added or changed provisions to the Policy. It is effective only when signed by us. It is subject to all conditions, limitations and exclusions of the Policy, except for those that are specifically amended.

Annual Deductible - the total of the Allowed Amount you must incur for Covered Health Care Services per year before we will begin paying for Benefits. It does not include any amount that exceeds Allowed Amounts. The *Schedule of Benefits* will tell you if your plan is subject to payment of an Annual Deductible and how it applies.

Assisted Reproductive Technology (ART) - the term for procedures involving the manipulation of human reproductive materials (such as sperm, eggs and/or embryos) to achieve Pregnancy. Examples of such procedures are:

- Gamete intrafallopian transfer (GIFT).
- Pronuclear stage tubal transfer (PROST).
- Tubal embryo transfer (TET).
- Zygote intrafallopian transfer (ZIFT).

Note that for purposes of coverage under this Policy, the term "Assisted Reproductive Technology" does not include in vitro fertilization procedures. See *In Vitro Fertilization* above under *Additional Benefits Required by Maryland Law* in *Section 1: Covered Health Care Services* for a description of the in vitro fertilization Benefit available to you.

Autism Spectrum Disorder - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Benefits - your right to payment for Covered Health Care Services that are available under the Policy.

Cellular Therapy - administration of living whole cells into a patient for the treatment of disease.

Co-insurance - the charge, stated as a percentage of the Allowed Amount, that you are required to pay for certain Covered Health Care Services.

Complex or Chronic Medical Condition - a physical, behavioral or developmental condition that may have no known cure, is progressive or can be debilitating or fatal if left untreated or undertreated, which includes multiple sclerosis, hepatitis C and rheumatoid arthritis.

Congenital Anomaly - a physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.

Co-payment - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Care Services.

Please note that for Covered Health Care Services, you are responsible for paying the lesser of the following:

- The Co-payment.
- The Allowed Amount.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function.

Covered Health Care Service(s) - health care services, including supplies or Pharmaceutical Products, which we determine to be all of the following:

- Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
- Medically Necessary.
- Described as a Covered Health Care Service in this *Certificate* under *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*.
- Not excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.

Covered Person - the Subscriber or a Dependent, but this term applies only while the person is enrolled under the Policy. We use "you" and "your" in this *Certificate* to refer to a Covered Person.

Custodial Care - services that are any of the following non-Skilled Care services:

- Non health-related services such as help with daily living activities. Examples include eating, dressing, bathing, transferring and ambulating.
- Health-related services that can safely and effectively be performed by trained non-medical personnel and are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function, as opposed to improving that function to an extent that might allow for a more independent existence.

Definitive Drug Test - test to identify specific medications, illicit substances and metabolites and is qualitative or quantitative to identify possible use or non-use of a drug.

Dependent - the Subscriber's legal spouse or a child of the Subscriber or the Subscriber's spouse. All references to the spouse of a Subscriber shall include a Domestic Partner, except for the purpose of coordinating Benefits with Medicare. As described in *Section 3: When Coverage Begins*, the Group determines who is eligible to enroll and who qualifies as a Dependent. The term "child" includes:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A grandchild who is unmarried and a Dependent of the Subscriber or the Subscriber's spouse.
- A child for whom legal custody or testamentary or court appointed guardianship other than temporary guardianship of less than 12 months duration has been awarded to the Subscriber or the Subscriber's spouse.
- A child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. We are responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order*.

When coverage is required through a court or other administrative order, we will do the following:

- Permit the insuring parent to enroll the child in Dependents coverage and include the child in that coverage regardless of enrollment period restrictions;
- If the Policy requires that the employee be enrolled in order for the child to be enrolled and the employee is not currently enrolled, we will enroll both the employee and the child regardless of enrollment period restrictions.
- In cases where the insuring parent does not enroll the child as a Dependent, permit the non-insuring parent, child support enforcement agency, or *Department of Health and Mental Hygiene* to apply for enrollment on behalf of the child and include the child under the coverage regardless of enrollment period restrictions;
- We will not end health insurance coverage for the child unless written evidence is provided to the entity that:
 - The order is no longer in effect;
 - The child has been or will be enrolled under other reasonable health insurance coverage that will take effect on or before the effective date of the termination;
 - The employer has eliminated the Dependents coverage for all its employees; or
 - The employer no longer employs the insuring parent, except that if the parent elects to exercise the provisions of the federal *Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)*, coverage shall be provided for the child consistent with the employer's plan for post-employment health insurance coverage for Dependents.
- We will not deny enrollment on the basis that the child:
 - ◆ Was born out of wedlock;
 - ◆ Is not claimed as a Dependent on the Subscriber's federal income tax return;
 - ◆ Does not reside with the Subscriber; or

- ◆ Is receiving benefits or is eligible to receive benefits under the *Maryland Medical Assistance Program*.

The following conditions apply:

- A Dependent includes a child listed above under age 26.
- A child is no longer eligible as a Dependent on the last day of the month following the date the child reaches age 26. This does not apply to the provisions outlined in *Section 4: When Coverage Ends under Coverage for a Disabled Dependent Child*.

A child who meets the requirements set forth above ceases to be eligible as a Dependent on the last day of the month following the date the child reaches age.

The Subscriber must reimburse us for any Benefits paid during a time a child did not satisfy these conditions.

A Dependent does not include anyone who is also enrolled as a Subscriber. No one can be a Dependent of more than one Subscriber.

Designated Dispensing Entity - a pharmacy or other provider that has entered into an agreement with us, or with an organization contracting on our behalf, to provide Pharmaceutical Products for the treatment of specified diseases or conditions. Not all Network pharmacies or Network providers are Designated Dispensing Entities.

Designated Network Benefits - the description of how Benefits are paid for certain Covered Health Care Services provided by a provider or facility that has been identified as a Designated Provider. The *Schedule of Benefits* will tell you if your plan offers Designated Network Benefits and how they apply.

Designated Provider - a provider and/or facility that:

- Has entered into an agreement with us, or with an organization contracting on our behalf, to provide Covered Health Care Service for the treatment of specific diseases or condition; or
- We have identified through our designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures.

A Designated Provider may or may not be located within the Service Area. Not all Network Hospitals or Network Physicians are Designated Providers.

You can find out if your provider is a Designated Provider by contacting us at www.myuhc.com or the telephone number on your ID card.

Designated Virtual Network Provider - a provider or facility that has entered into an agreement with us, or with an organization contracting on our behalf, to deliver Covered Health Care Services through live audio with video technology or audio only.

Domestic Partner - an individual in a relationship with another individual of the same or opposite sex, provided both individuals:

- Are at least eighteen (18) years old;
- Are not related to each other by blood or marriage within four degrees of consanguinity under civil law rule;
- Are not married or in a civil union or domestic partnership with another individual;
- Have been financially interdependent for at least six (6) consecutive months prior to application in which each individual contributes to some extent to the other individual's maintenance and support with the intention of remaining in the relationship indefinitely; and

- Share a common primary residence.

Drug Misuse - unlawful use of a drug, drug abuse or drug dependence. Drug abuse is a disease which is characterized by a pattern of pathological use of a drug with repeated attempts to control the use, and with significant negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social. Drug dependence is a disease characterized by drug abuse and physical symptoms of withdrawal or tolerance.

Durable Medical Equipment (DME) - medical equipment that is all of the following:

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered DME.
- Not of use to a person in the absence of a disease or disability.
- Serves a medical purpose for the treatment of a Sickness or Injury.
- Primarily used within the home.

Eligible Person - an employee of the Group or other person connected to the Group who meets the eligibility requirements shown in both the Group's *Application* and the Policy. An Eligible Person must live and/or work within the Service Area.

Emergency - a medical condition manifesting 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 Covered Person (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.

Emergency Health Care Services - with respect to an Emergency:

- A medical screening exam (as required under *section 1867* of the *Social Security Act, 42 U.S.C. 1395dd*) 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, and
- Such further medical exam and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under *section 1867* of the *Social Security Act (42 U.S.C. 1395dd(e)(3))*.

Enrolled Dependent - a Dependent who is properly enrolled under the Policy.

Experimental or Investigational Service(s) - medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use, except for coverage of a drug for an Off-Label Use of the drug if the drug is recognized for treatment in any of the standard reference compendia or in the medical literature.

- Subject to review and approval by the institutional review board of the treating facility for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- Clinical trials for which Benefits are available as described under *Clinical Trials* in *Section 1: Covered Health Care Services*.
- We may consider an otherwise Experimental or Investigational Service to be a Covered Health Care Service for that Sickness or condition if:
 - You are not a participant in a qualifying clinical trial, as described under *Clinical Trials* in *Section 1: Covered Health Care Services*; and
 - You have a Sickness or condition that is likely to cause death within one year of the request for treatment.

Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Freestanding Facility - an outpatient, diagnostic or ambulatory center or independent laboratory which performs services and submits claims separately from a Hospital.

Gene Therapy - therapeutic delivery of nucleic acid (DNA or RNA) into a patient's cells as a drug to treat a disease.

Genetic Counseling - counseling by a qualified clinician that includes:

- Identifying your potential risks for suspected genetic disorders;
- An individualized discussion about the benefits, risks and limitations of Genetic Testing to help you make informed decisions about Genetic Testing; and
- Interpretation of the Genetic Testing results in order to guide health decisions.

Certified genetic counselors, medical geneticists and physicians with a professional society's certification that they have completed advanced training in genetics are considered qualified clinicians when Covered Health Care Services for Genetic Testing require Genetic Counseling.

Genetic Testing - exam of blood or other tissue for changes in genes (DNA or RNA) that may indicate an increased risk for developing a specific disease or disorder, or provide information to guide the selection of treatment of certain diseases, including cancer.

Gestational Carrier - a female who becomes pregnant by having a fertilized egg (embryo) implanted in her uterus for the purpose of carrying the fetus to term for another person. The Gestational Carrier does not provide the egg and is therefore not biologically related to the child.

Group - the employer, or other defined or otherwise legally established group, to whom the Policy is issued.

Home Health Agency - a program or organization authorized by law to provide health care services in the home. The definition of Home Health Agency includes both of the following:

- A Hospital that has a valid operating certificate and is certified to provide home health care services; or

- A public or private health service or agency that is licensed as a Home Health Agency under *Title 19, Subtitle 4 of the Maryland Health - General Article* to provide coordinated home health care.

Hospital - an institution that is operated as required by law and that meets both of the following:

- It is mainly engaged in providing inpatient health care services, for the short term care and treatment of injured or sick persons. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not mainly a place for rest, Custodial Care or care of the aged. It is not a nursing home, convalescent home or similar institution.

Hospital-based Facility - an outpatient facility that performs services and submits claims as part of a Hospital.

Initial Enrollment Period - the first period of time when Eligible Persons may enroll themselves and their Dependents under the Policy.

Injury - damage to the body, including all related conditions and symptoms.

Inpatient Rehabilitation Facility - any of the following that provides inpatient rehabilitation health care services (including physical therapy, occupational therapy and/or speech therapy), as authorized by law:

- A long term acute rehabilitation center,
- A Hospital, or
- A special unit of a Hospital designated as an Inpatient Rehabilitation Facility.

Inpatient Stay - a continuous stay that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Behavioral Therapy (IBT) - outpatient Mental Health Care Services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders. The most common IBT is *Applied Behavior Analysis (ABA)*.

Intensive Outpatient Treatment - a structured outpatient mental health or substance-related and addictive disorders treatment program. The program may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermittent Care - skilled nursing care that is provided either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in certain circumstances when the need for more care is finite and predictable.

Manipulative Treatment (adjustment) - a form of care provided by chiropractors and osteopaths for diagnosed muscle, nerve and joint problems. Body parts are moved either by hands or by a small instrument to:

- Restore or improve motion.
- Reduce pain.
- Increase function.

Medically Necessary - health care services that are all of the following as determined by us or our designee:

- In accordance with *Generally Accepted Standards of Medical Practice*.
- Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We have the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be determined by us.

We develop and maintain clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revised from time to time), are available to Covered Persons through www.myuhc.com or the telephone number on your ID card. They are also available to Physicians and other health care professionals on UHCprovider.com.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act*, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Care Services - services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or the *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Care Service.

Mental Health/Substance-Related and Addictive Disorders Designee - the organization or individual, designated by us, that provides or arranges Mental Health Care Services and Substance-Related and Addictive Disorders Services.

Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Care Service.

Mobility Device - A manual wheelchair, electric wheelchair, transfer chair or scooter.

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with us or with our affiliate to participate in

our Network. This does not include those providers who have agreed to discount their charges for Covered Health Care Services by way of their participation in the Shared Savings Program. Our affiliates are those entities affiliated with us through common ownership or control with us or with our ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Care Services, but not all Covered Health Care Services, or to be a Network provider for only some of our products. In this case, the provider will be a Network provider for the Covered Health Care Services and products included in the participation agreement and an out-of-Network provider for other Covered Health Care Services and products. The participation status of providers will change from time to time.

Network Benefits - the description of how Benefits are paid for Covered Health Care Services provided by Network providers. The *Schedule of Benefits* will tell you if your plan offers Network Benefits and how Network Benefits apply.

New Pharmaceutical Product - a Pharmaceutical Product or new dosage form of a previously approved Pharmaceutical Product. It applies to the period of time starting on the date the Pharmaceutical Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ends on the earlier of the following dates:

- The date as determined by us or our designee, which is based on when the Pharmaceutical Product is reviewed and when utilization management strategies are implemented.
- December 31st of the following calendar year.

Off-Label Use - the prescription of a drug for a treatment other than those treatments stated in the labeling approved by the federal *U.S. Food and Drug Administration (FDA)*.

Open Enrollment Period - a period of time, after the Initial Enrollment Period, when Eligible Persons may enroll themselves and Dependents under the Policy. The Group sets the period of time that is the Open Enrollment Period.

Out-of-Pocket Limit - the maximum amount you pay every year. The *Schedule of Benefits* will tell you if your plan is subject to an Out-of-Pocket Limit and how the Out-of-Pocket Limit applies.

Partial Hospitalization/Day Treatment - the provision of medically directed intensive or intermediate short term treatment:

- To a Covered Person;
- In a licensed or certified facility or program;
- For Mental Illness, emotional disorders, Drug Misuse, or Alcohol Misuse; and
- For a period of less than 24 hours but more than 4 hours in a day.

Per Occurrence Deductible - the portion of the Allowed Amount (stated as a set dollar amount) that you must incur for certain Covered Health Care Services prior to, and in addition to, any Annual Deductible before we begin paying Benefits for those Covered Health Care Services.

When a plan has a Per Occurrence Deductible, you are responsible for paying the lesser of the following:

- The applicable Per Occurrence Deductible.
- The Allowed Amount.

The *Schedule of Benefits* will tell you if your plan is subject to payment of a Per Occurrence Deductible and how the Per Occurrence Deductible applies.

Pharmaceutical Product(s) - *U.S. Food and Drug Administration (FDA)*-approved prescription medications or products administered in connection with a Covered Health Care Service by a Physician.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Policy.

Policy - the entire agreement issued to the Group that includes all of the following:

- *Group Policy.*
- *Certificate.*
- *Schedule of Benefits.*
- *Group Application.*
- *Riders.*
- *Amendments.*

These documents make up the entire agreement that is issued to the Group.

Policy Charge - the sum of the Premiums for all Covered Persons enrolled under the Policy.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

Premium - the periodic fee required for each Subscriber and each Enrolled Dependent, in accordance with the terms of the Policy.

Presumptive Drug Test - test to determine the presence or absence of drugs or a drug class in which the results are indicated as negative or positive result.

Primary Care Physician - a Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:

- Services exceed the scope of Intermittent Care in the home.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.
- Skilled nursing resources are available in the facility.
- The Skilled Care can be provided by a Home Health Agency on a per visit basis for a specific purpose.

Rare Medical Condition - a disease or condition that affects fewer than 200,000 individuals in the United States or approximately 1 in 1,500 individuals worldwide. Rare Medical Condition includes cystic fibrosis, hemophilia and multiple myeloma.

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

- Provided to a child or adult with a Mental Illness who is experiencing or is at risk of psychiatric crisis that would impair the individual's ability to function in the community.
- Designed to prevent a psychiatric inpatient admission, provide an alternative to psychiatric inpatient admission, or shorten the length of inpatient stay;
- Provided out of the Covered Person's residence on a short-term basis in a community-based residential setting; and
- Provided by entities that are licensed by the *Department of Health and Mental Hygiene* to provide Residential Crisis Services.

Residential Treatment - treatment in a facility established and operated as required by law, which provides Mental Health Care Services or Substance-Related and Addictive Disorders Services. It must meet all of the following requirements:

- Provides a program of treatment, approved by the Mental Health/Substance-Related and Addictive Disorders Designee, under the active participation and direction of a Physician and, approved by the Mental Health/Substance-Related and Addictive Disorder Designee.
- Has or maintains a written, specific and detailed treatment program requiring your full-time residence and participation.
- Provides at least the following basic services in a 24-hour per day, structured setting:
 - Room and board.
 - Evaluation and diagnosis.
 - Counseling.
 - Referral and orientation to specialized community resources.

A Residential Treatment facility that qualifies as a Hospital is considered a Hospital.

Rider - any attached written description of additional Covered Health Care Services not described in this *Certificate*. Covered Health Care Services provided by a Rider may be subject to payment of additional Premiums. Note that Benefits for Outpatient Prescription Drugs, while presented in Rider format, are not subject to payment of additional Premiums and are included in the overall Premium for Benefits under the Policy. Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended in the Rider.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Care Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is Medically Necessary, or when a Semi-private Room is not available.

Service Area - the geographic area we serve, which has been approved by the appropriate regulatory agency. Contact us to determine the exact geographic area we serve. The Service Area may change from time to time.

Shared Savings Program- a program in which we may obtain a discount to an out-of-Network provider's billed charges. This discount is usually based on a schedule previously agreed to by the out-of-Network provider and a third-party vendor. If the out-of-Network provider agrees to participate in the Shared Savings Program,, they must accept the discounted rates. When this happens, you may experience lower out-of-pocket amounts. Co-insurance and any applicable deductible would still apply to the reduced charge. Policy provisions or administrative practices supersede the scheduled rate, and a different rate is determined by us. This means, when permitted by our Shared Savings Program contract, we will pay the lesser of the Shared Savings Program, discount or an amount determined by us, such as a percentage of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or

similar service within the geographic market, an amount determined based on available data resources of competitive fees in that geographic area, a fee schedule established by a third party vendor or a negotiated rate with the provider. In this case, the out-of-Network provider may bill you for the difference between the billed amount and the rate determined by us. If this happens, you should call the telephone number shown on your ID card. for assistance with resolving the issue. Shared Savings Program providers are not Network providers and are not credentialed by us.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this *Certificate* includes Mental Illness or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorder.

Skilled Care - skilled nursing, skilled teaching, skilled habilitation and skilled rehabilitation services when all of the following are true:

- Must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- Ordered by a Physician.
- Not delivered for the purpose of helping with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- Requires clinical training in order to be delivered safely and effectively.
- Not Custodial Care, which can safely and effectively be performed by trained non-medical personnel.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

Specialist - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Specialty Prescription Drug Pharmaceutical Product - Pharmaceutical products that are prescribed for an individual with a complex or chronic medical condition or a rare medical condition that costs \$600 or more for up to a 30-day supply, is not typically stocked at retail pharmacies and requires a difficult or unusual process of delivery to the patient in the preparation, handling, storage, inventory, or distribution of the drug or the pharmaceutical products require enhanced patient education, management, or support, beyond those required for traditional dispensing, before or after administration of the drug. Specialty Prescription Drug Pharmaceutical Products do not include drugs prescribed to treat diabetes, HIV or AIDS.

Subscriber - an Eligible Person who is properly enrolled under the Policy. The Subscriber is the person (who is not a Dependent) on whose behalf the Policy is issued to the Group.

Substance-Related and Addictive Disorders Services - services for the diagnosis and treatment of Alcohol Misuse and Drug Misuse.

Surrogate - a female who becomes pregnant usually by artificial insemination or transfer of a fertilized egg (embryo) for the purpose of carrying the fetus for another person.

Total Disability or Totally Disabled - a Subscriber's inability to perform all of the substantial and material duties of his or her regular employment or occupation; and a Dependent's inability to perform the normal activities of a person of like age and sex.

Transitional Living - Mental Health Care Services and Substance-Related and Addictive Disorders Services provided through facilities, group homes and supervised apartments which provide 24-hour supervision and are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. They provide stable and safe housing, an alcohol/drug-free environment and support for recovery. They may be

used as an addition to ambulatory treatment when it doesn't offer the intensity and structure needed to help you with recovery.

- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments. They provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. They may be used as an addition to treatment when it doesn't offer the intensity and structure needed to help you with recovery.

Unproven Service(s) - services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

We have a process by which we compile and review clinical evidence with respect to certain health care services. From time to time, we issue medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com.

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, as we determine, consider an otherwise Unproven Service to be a Covered Health Care Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Urgent Care Center - a facility that provides Covered Health Care Services that are required to prevent serious deterioration of your health. These services are required as a result of an unforeseen Sickness, Injury, or the onset of sudden or severe symptoms.

No Surprises Act Amendment

UnitedHealthcare of the Mid-Atlantic, Inc.

The Group Policy to which this amendment is attached is amended as described below.

Definitions

The following definitions are being added to the Group Policy and apply only to the provisions in this amendment:

"Air ambulance service" means medical transport by a rotary wing air ambulance, as defined in 42 CFR 414.605, or fixed wing air ambulance, as defined in 42 CFR 414.605, for patients.

"Ancillary services" means:

1. items and services furnished by a non-participating provider in a participating facility related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner;
2. items and services provided by assistant surgeons, hospitalists, and intensivists;
3. diagnostic services, including radiology and laboratory services; and
4. items and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at such facility.

"Authorized representative" means an individual authorized under State law to provide consent on behalf of a patient, provided that the individual is not a provider affiliated with the facility or employee of the facility, unless such provider or employee is a family member of the patient.

"Continuing care patient" means an individual who, with respect to a provider or facility:

1. is undergoing a course of treatment for a serious and complex condition from the provider or facility;
2. is undergoing a course of institutional or inpatient care from the provider or facility;
3. is scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
4. is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
5. is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

"Emergency facility" means an emergency department of a hospital, or an independent freestanding emergency department where emergency services are provided. "Emergency facility" includes a hospital, regardless of the department of the hospital, in which items or services with respect to emergency services are provided by a non-participating provider or non-participating emergency facility: after the individual is stabilized; and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which other emergency services are furnished.

"Emergency medical condition" means a medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such 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:

1. 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;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

"Emergency services" means, with respect to an emergency medical condition:

1. An appropriate medical screening examination (as required under section 1867 of the *Social Security Act*, 42 U.S.C. 1395dd, or as would be required under such section if such section applied to an independent freestanding emergency department) that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition;
2. Within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment, as are required under section 1867 of the *Social Security Act* (42 U.S.C. 1395dd) or as would be required under such section if such section applied to an independent freestanding emergency department, to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished); and
3. Except as provided in item 4. below, covered services that are furnished by a nonparticipating provider or nonparticipating emergency facility after the individual is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the services described in item 1. above are furnished.
4. The covered services described in item 3. above are not included as emergency services if all of the following conditions are met:
 - a. The attending emergency physician or treating provider determines that the individual is able to travel using nonmedical transportation or nonemergency medical transportation to an available participating provider or facility located within a reasonable travel distance, taking into account the individual's medical condition;
 - b. The provider or facility furnishing such additional items and services satisfies the notice and consent criteria of 45 C.F.R § 149.420(c) through (g) with respect to such items and services, provided that the written notice additionally satisfies items 4.b.i. and ii. below, as applicable:
 - i. In the case of a participating emergency facility and a nonparticipating provider, the written notice must also include a list of any participating providers at the facility who are able to furnish such items and services involved and notification that the participant, beneficiary, or enrollee may be referred, at their option, to such a participating provider.
 - ii. In the case of a nonparticipating emergency facility, the written notice must include the good faith estimated amount that the individual may be charged for items or services furnished by the nonparticipating emergency facility or by nonparticipating providers with respect to the visit at such facility (including any item or service that is reasonably expected to be furnished by the nonparticipating emergency facility or nonparticipating providers in conjunction with such items or services);
 - c. The individual (or an authorized representative of such individual) is in a condition to receive the information described in item b. above, as determined by the attending emergency physician or treating provider using appropriate medical judgment, and to provide informed consent in accordance with applicable State law; and

- d. The covered services are not rendered by a health care provider who is subject to § 19-710(p) of the *Health-General Article*.

"Independent freestanding emergency department" means a health care facility that is geographically separate and distinct and licensed separately from a hospital under applicable State law; and provides any emergency services.

"Non-participating emergency facility" means an emergency facility that has not contracted directly with us or indirectly, such as through an entity contracting on behalf of us to provide health care services to our enrollees.

"Non-participating provider" means a physician or other health care provider that has not contracted directly with us or an entity contracting on behalf of us to provide health care services to our enrollees.

"Other health care provider" means any person who is licensed or certified under applicable State law to provide health care services, and is acting within the scope of practice of that provider's license or certification, but does not include a provider of air ambulance services.

"Out-of-network rate" means, with respect to an item or service furnished by a non-participating provider, non-participating emergency facility, or non-participating provider of air ambulance services:

1. In a State that has an *All-Payer Model Agreement* under section 1115A of the *Social Security Act* that applies to the plan/carrier, non-participating provider/non-participating emergency facility, and item/service, the amount that the State approves under the *All-Payer Model Agreement* for the item or service. For certain items or services billed by Maryland hospitals, this is the amount for the item or service approved by the *Health Services Cost Review Commission (HSCRC)*.
2. If there is no such *All-Payer Model Agreement* applicable to the item or service, but a specified State law is in effect and applicable, the amount for the item or service determined in accordance with such specified State law. Under specified Maryland law, this is the amount required by § 19-710.1 of the *Health-General Article*.
3. If there is no such *All-Payer Model Agreement* or specified State law applicable to the item or service, an amount agreed upon by us and the nonparticipating provider or non-participating emergency facility.
4. If none of the three conditions above apply, an amount determined by a certified independent dispute resolution (IDR) entity under the IDR process described in section 2799A-1(c) or 2799A-2(b) of the federal *Public Health Service Act*, as applicable.

"Participating emergency facility" means any emergency facility that has contracted directly with us or an entity contracting on behalf of us to provide health care services to our enrollees. A single case agreement between an emergency facility and us that is used to address unique situations in which an enrollee requires services that typically occur out-of-network constitutes a contractual relationship for purposes of this definition, and is limited to the parties to the agreement.

"Participating facility" means a health care facility that has contracted directly with us or an entity contracting on behalf of us to provide health care services to our enrollees. A single case agreement between a health care facility and us that is used to address unique situations in which an enrollee requires services that typically occur out-of-network constitutes a contractual relationship for purposes of this definition, and is limited to the parties to the agreement. Additionally, for purposes of this definition and in the context of non-emergency services, "health care facility" is limited to a hospital (as defined in section 1861(e) of the *Social Security Act*); a hospital outpatient department; a critical access hospital (as defined in section 1861(mm)(1) of the *Social Security Act*); and an ambulatory surgical center described in section 1833(i)(1)(A) of the *Social Security Act*.

"Participating provider" means a physician or other health care provider that has contracted directly with us or an entity contracting on behalf of us to provide health care services to our enrollees.

"Qualifying payment amount" means the amount calculated using the methodology described in 45 C.F.R. § 149.140(c), which is based on the median contracted rate for all plans offered by the carrier in the same insurance market for the same or similar item or service that is: provided by a provider in the same or similar specialty or facility of the same or similar facility type; and provided in the geographic region in which the item or service is furnished. The median contracted rate is subject to additional adjustments specified in federal regulations.

"Recognized amount" means, with respect to an item or service furnished by a non-participating provider or non-participating emergency facility, an amount that is determined as follows:

1. In a State that has an *All-Payer Model Agreement* under section 1115A of the *Social Security Act* that applies to the plan/carrier, non-participating provider/non-participating emergency facility, and item/service, the amount that the State approves under the *All-Payer Model Agreement* for the item or service. For certain items or services billed by Maryland hospitals, this is the amount for the item or service approved by the *HSCRC*.
2. If there is no such *All-Payer Model Agreement* applicable to the item or service, in a State that has in effect a specified State law, the amount for the item or service determined in accordance with such specified State law. Under specified Maryland law, this is the amount required by § 19-710.1 of the *Health-General Article*.
3. If neither an *All-Payer Model Agreement* or a specified State law apply to the item or service, the lesser of: the amount billed by the non-participating provider or nonparticipating emergency facility, or the qualifying payment amount.

"Serious or complex condition" means in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or in the case of a chronic illness or condition, a condition that is life-threatening, degenerative, potentially disabling, or congenital; and requires specialized medical care over a prolonged period of time.

"To stabilize," with respect to an emergency medical condition, means to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

"Treating provider" means a physician or other health care provider who has evaluated the individual.

"Visit" means the instance of going to or staying at a health care facility, and, with respect to items and services furnished to an individual at a health care facility, includes, in addition to items and services furnished by a provider at the facility, equipment and devices, telemedicine services, imaging services, laboratory services, and preoperative and postoperative services, regardless of whether the provider furnishing such items or services is at the facility.

Emergency Services

Any provision of the contract that provides benefits with respect to services in an emergency department of a hospital or with respect to emergency services in an independent freestanding emergency department, is amended to provide emergency services:

1. Without the need for any prior authorization determination, even if the emergency services are provided on an out-of-network basis;
2. Without regard to whether the health care provider furnishing the emergency services is a participating provider or a participating emergency facility, as applicable, with respect to the services;
3. If the emergency services are provided by a non-participating provider or nonparticipating emergency facility, without imposing any administrative requirement or limitation on coverage that

is more restrictive than the requirements or limitations that apply to emergency services received from participating providers;

4. Without limiting what constitutes an emergency medical condition solely on the basis of diagnosis codes; and
5. Without regard to any other term or condition of the coverage, other than:
 - a. applicable cost-sharing; and
 - b. for emergency services provided for a condition that is not an emergency medical condition, the exclusion or coordination of benefits.

Cost-Sharing Requirements, Payment and Balance Billing Protections for Emergency Services

1. If any copayment amount, coinsurance percentage, or other cost-sharing requirement described in the contract for emergency services is different for a service received from a participating provider or participating emergency facility than for a service received from a non-participating provider or non-participating emergency facility, the copayment amount, coinsurance percentage, and/or other cost-sharing requirement for emergency services provided by a non-participating provider or non-participating emergency facility is amended to be the same as the copayment amount, coinsurance percentage, and/or other cost-sharing requirement listed in the contract for emergency services provided by a participating provider or participating emergency facility;
2. If the contract has separate in-network and out-of-network deductibles or separate in-network and out-of-network out-of-pocket maximums, the contract is amended to provide that any cost-sharing payments made with respect to emergency services provided by a nonparticipating provider or a nonparticipating emergency facility will be counted toward any applicable in-network deductible and in-network out-of-pocket maximum;
3. The contract is amended to provide that if emergency services are provided by a nonparticipating provider or nonparticipating emergency facility, any cost-sharing requirement will be calculated based on the recognized amount;
4. If emergency services are provided by a non-participating provider or non-participating emergency facility, we will make payment for the covered emergency services directly to the non-participating provider or non-participating emergency facility. The payment amount will be equal to the amount by which the out-of-network rate exceeds the cost-sharing amount for the services; and
5. Any provisions of the contract that describe the enrollee's responsibility for charges for emergency services furnished by non-participating providers or non-participating emergency facilities are amended to provide that the enrollee will not be liable for an amount that exceeds the enrollee's cost-sharing requirement under this amendment.

Cost-sharing Requirements, Payment and Balance Billing Protections for Non-Emergency Services Performed by Non-participating Providers at Participating Facilities, including Ancillary Services and Services for Unforeseen Urgent Medical Needs

The contract is amended to cover items and services furnished by a nonparticipating provider with respect to a covered visit at a participating facility in the following manner, except when the non-participating provider has satisfied the notice and consent criteria of 45 C.F.R. § 149.420 (c) through (i):

1. The copayment amount, coinsurance percentage, and/or other cost-sharing requirement for such items and services furnished by a nonparticipating provider with respect to a visit in a participating facility is the same as the copayment amount, coinsurance percentage, and/or other cost-sharing

requirement listed in the contract for the items and services when provided by a participating provider;

2. Any cost-sharing requirement for the items and services will be calculated based on the recognized amount;
3. Any cost-sharing payments made with respect to the items and services will be counted toward any applicable in-network deductible and in-network out-of-pocket maximum;
4. We will make payment for the items and services directly to the nonparticipating provider. The payment amount will be equal to the amount by which the out-of-network rate exceeds the cost-sharing amount for the items and services; and
5. Any provisions of the contract that describe the enrollee's responsibility for charges for such items or services that exceed our payment are amended to provide that the enrollee will not be liable for an amount that exceeds the enrollee's cost-sharing requirement under this amendment.

Provisions 1 - 5 above are not applicable when the non-participating provider has satisfied the notice and consent criteria of 45 C.F.R. § 149.420 (c) through (i), including providing notice to the enrollee of the estimated charges for the items and services and that the provider is a nonparticipating provider, and obtaining consent from the enrollee to be treated and balance billed by the non-participating provider. The notice and consent criteria of 45 C.F.R. § 149.420 (c) through (i) do not apply to non-participating providers with respect to:

1. covered services rendered by a health care provider for which payment is required under § 19-710.1 of the *Health-General Article*;
2. ancillary services; and
3. items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the nonparticipating provider satisfied the notice and consent criteria;

and such items and services furnished by non-participating providers will always be subject to the above five provisions.

Cost-sharing Requirements, Payment and Balance Billing Protections for Nonparticipating Providers of Air Ambulance Services

Any provision of the contract that provides benefits with respect to air ambulance services is amended to provide the following when services are received from a non-participating provider of air ambulance services:

1. The copayment amount, coinsurance percentage, and/or other cost-sharing requirement for the air ambulance service is the same as the copayment amount, coinsurance percentage, and/or other cost-sharing requirement listed in the contract for air ambulance services when provided by a participating provider of ambulance services;
2. Any cost-sharing requirement will be calculated based on the lesser of the qualifying payment amount or the billed amount for the services;
3. Any cost-sharing payments made with respect to the air ambulance service will be counted toward any applicable in-network deductible and in-network out-of-pocket maximum;
4. We will make payment for the air ambulance services directly to the non-participating provider of ambulance services. The payment amount will be equal to the amount by which the out-of-network rate exceeds the cost-sharing amount for air ambulance services; and
5. Any provisions of the contract that describe the enrollee's responsibility for charges for covered air ambulance services furnished by non-participating providers are amended to provide that the

enrollee will not be liable for an amount that exceeds the enrollee's cost-sharing requirement under this amendment.

Cost-sharing and Balance Billing Protections for Services Provided Based on Reliance on Incorrect Provider Network Information

If an enrollee is furnished, by a nonparticipating provider, an item or service that would otherwise be covered if provided by a participating provider, and the enrollee relied on a database, provider directory, or information regarding the provider's network status provided by us through a telephone call or electronic, web-based, or Internet-based means which incorrectly indicated that the provider was a participating provider for the furnishing of such item or service, then the following apply:

1. The copayment amount, coinsurance percentage, and/or other cost-sharing requirement for such item or service furnished by a nonparticipating provider is the same as the copayment amount, coinsurance percentage, and/or other cost-sharing requirement listed in the contract for the item or service when provided by a participating provider; and
2. Any cost-sharing payments made with respect to the item or service will be counted toward any applicable in-network deductible and in-network out-of-pocket maximum.
3. The enrollee will not be liable for an amount that exceeds the cost-sharing that would have applied to the enrollee if the provider was a participating provider.

Continuity of Care

A continuing care patient receiving care from a participating provider may elect to continue to receive transitional care from such provider if the provider's participating provider contract is terminated or non-renewed for reasons other than for failure to meet applicable quality standards or for fraud; or if the Group Policy terminates resulting in a loss of benefits with respect to such provider or facility. We will notify each enrollee who is a continuing care patient at the time of termination or non-renewal on a timely basis of such termination and the enrollee's right to elect transitional care.

When elected, benefits will be provided under the same terms and conditions as would have applied with respect to items and services that would have been covered had termination not occurred, with respect to the course of treatment provided by such provider or facility relating to the enrollee's status as a continuing care patient. Benefits will be provided during the period beginning on the date we notify the continuing care patient of the termination and ending on the earlier of: (i) 90 days after the date of such notice; or (ii) the date on which such enrollee is no longer a continuing care patient with respect to such provider or facility.

The enrollee will not be liable for an amount that exceeds the cost-sharing that would have applied to the enrollee had the termination not occurred.

UNITEDHEALTHCARE INSURANCE COMPANY



Joseph A. Ochipinti, President and CEO

Outpatient Prescription Drug

UnitedHealthcare of the Mid-Atlantic, Inc.

Schedule of Benefits

When Are Benefits Available for Prescription Drug Products?

Benefits are available for Prescription Drug Products at a Network Pharmacy and are subject to Co-payments and/or Co-insurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is placed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Care Service or is prescribed to prevent conception. Refer to the definition of *Covered Health Care Services* in *Section 9: Defined Terms* of the *Certificate of Coverage Amendment*.

What Happens When a Brand-name Drug Becomes Available as a Generic?

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change. Therefore your Co-payment and/or Co-insurance may change or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

However, we will provide immediate coverage for a Brand-name Prescription Drug Product if, in the judgment of the Authorized Prescriber:

- The Generic Prescription Drug Product is not equivalent to the Brand-name Prescription Drug Product; or
- The covered Generic Prescription Drug Product on the Prescription Drug List:
 - ◆ Has been ineffective in treating a Covered Person's disease or condition; or
 - ◆ Has caused or is likely to cause an adverse reaction or other harm to the Covered Person.
 - ◆ For a contraceptive prescription drug or device, the prescription drug or device that is not on the formulary is medically necessary for the Covered Person to adhere to the appropriate use of the prescription drug or device.

What are the Benefits for Oral Chemotherapeutic Agents?

Oral chemotherapeutic agent Prescription Drug Products will be provided at a level no less favorable than chemotherapeutic agents are provided under *Therapeutic Treatments - Outpatient* in your *Certificate of Coverage*. If the cost share for Pharmaceutical Products is based on tier placement, the cost sharing for oral chemotherapeutic agents will be no less favorable than the tier with the lowest cost-sharing for intravenous or injectable chemotherapy.

How Do Supply Limits Apply?

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Co-payment and/or Co-insurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed. Supply limits are subject, from time to time, to our review and change. This may limit the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply or up to a 90-day supply in a single dispensing of Maintenance Medications when prescribed by an Authorized Prescriber. If the Prescription Order for any Prescription Drug Product (including Maintenance Medications) exceeds the established additional supply limit, you will be charged an additional Co-payment or Co-insurance for the supply that exceeds the limit. If the cost sharing applied is Co-insurance rather than a Co-payment, your Co-insurance will reflect the number of days dispensed.

We will provide coverage for a single dispensing up to a 12-month supply of prescription contraceptives.

You may find out whether a Prescription Drug Product has a supply limit for dispensing by contacting us at www.myuhc.com or the telephone number on your ID card.

Do Prior Authorization Requirements Apply?

Before certain Prescription Drug Products are dispensed to you, your Physician or your pharmacist required to obtain prior authorization from us or our designee. The reason for obtaining prior authorization from us is to determine whether the Prescription Drug Product, in accordance with our approved guidelines, is each of the following:

- It meets the definition of a Covered Health Care Service.
- It is not an Experimental or Investigational or Unproven Service.

Network Pharmacy Prior Authorization

When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider, or the pharmacist are responsible for obtaining prior authorization from us.

Note: Prior Authorization is not required for a covered Prescription Drug Product: 1) when used for treatment of an opioid use disorder; and 2) that contains methadone, buprenorphine, naloxone hydrochloride or naltrexone.

Upon review of the documentation provided by the prescribing provider or the pharmacist, benefits may not be available for the Prescription Drug Product, if we determine that the Prescription Drug Product is not a Covered Health Care Service or it is an Experimental or Investigational or Unproven Service. Refer to the definition of *Covered Health Care Services* in *Section 9: Defined Terms* of the *Certificate of Coverage*.

Does Step Therapy Apply?

Certain Prescription Drug Products for which Benefits are described under this Prescription Drug Rider are subject to step therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product(s) first.

A step therapy requirement may not be imposed if:

- The step therapy drug has not been approved by the *U.S. Food and Drug Administration (FDA)* for the medical condition being treated; or
- The prescribing provider documents and notifies us that a Prescription Drug Product:

- Was ordered by the prescribing provider for the Covered Person within the past 180 days; and
 - Based on the professional judgment of the prescribing provider, was effective in treating the Covered Person's medical condition.
- The prescription drug has been approved by the *FDA* and:
 - Is being used to treat the Covered Person's stage four advanced metastatic cancer; and
 - Use of the prescription drug is consistent with the *FDA*-approved indication or the *National Comprehensive Cancer Network Drugs & Biologics Compendium* indication for the treatment of stage four advanced metastatic cancer; and
 - Is supported by peer-reviewed medical literature.

You may find out whether a Prescription Drug Product is subject to step therapy requirements by contacting us at www.myuhc.com or the telephone number on your ID card.

What Do You Pay?

You must incur expenses equal to the Annual Drug Deductible.

We will not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible.

You incur expenses equal to the applicable Co-payment and/or Co-insurance described in the Benefit Information table. You are not responsible for paying a Co-payment and/or Co-insurance for PPACA Zero Cost Share Preventive Care Medications.

Diabetic test strips are not subject to Deductible, Co-payment or Co-insurance.

The amount you pay for any of the following under this Rider will not be included in calculating any Out-of-Pocket Limit stated in your *Certificate*:

- Certain coupons or offers from pharmaceutical manufacturers or an affiliate. You may access information on which coupons or offers are not permitted by contacting us at www.myuhc.com or the telephone number on your ID card.
- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product. Our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

The Annual Drug Deductibles are calculated on a calendar year basis.

Payment Term And Description	Amounts
<p>Annual Drug Deductible</p>	
<p>The amount you must incur for covered Tier 3 and Tier 4 Prescription Drug Products at a Network Pharmacy in a calendar before we begin paying for Prescription Drug Products.</p> <p>Coupons: We will not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Drug Deductible. You may access information on which coupons or offers are not permitted by contacting us at www.myuhc.com or the telephone number on your ID card.</p> <p>Diabetic test strips are not subject to Deductible, Co-payment or Co-insurance.</p>	<p>\$250 per Covered Person, not to exceed \$500 for all Covered Persons in a family.</p>
<p>Co-payment and Co-insurance</p>	
<p>Co-payment</p> <p>Co-payment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount.</p> <p>Co-insurance</p> <p>Co-insurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge.</p> <p>Co-payment and Co-insurance</p> <p>Your Co-payment and/or Co-insurance is determined by the Prescription Drug List (PDL) Management Committee's tier placement of a Prescription Drug Product.</p> <p>We may cover multiple Prescription Drug Products for a single Co-payment and/or Co-insurance if the combination of these multiple products provides a therapeutic treatment regimen that is supported by available clinical evidence. You may determine whether a therapeutic treatment regimen qualifies</p>	<p>For Prescription Drug Products at a retail Network Pharmacy, you must incur the lowest of the following:</p> <ul style="list-style-type: none"> • The applicable Co-payment and/or Co-insurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. • The Prescription Drug Charge for that Prescription Drug Product. <p>For Prescription Drug Products from a mail order Network Pharmacy, you must incur the lower of the following:</p> <ul style="list-style-type: none"> • The applicable Co-payment and/or Co-insurance. • The Prescription Drug Charge for that Prescription Drug Product. <p>See the Co-payments and/or Co-insurance stated in the Benefit Information table for amounts.</p> <p>Your Co-payment and/or Co-insurance will never exceed the retail price of the Prescription Drug Product.</p> <p>You are not responsible for paying a Co-payment and/or Co-insurance for PPACA Zero Cost Share Preventive Care Medications.</p>

Payment Term And Description	Amounts
<p>for a single Co-payment and/or Co-insurance by contacting us at www.myuhc.com or the telephone number on your ID card.</p> <p>Co-payment/Co-insurance Waiver Program: If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we will waive your Co-payment and/or Co-insurance for one or more Prescription Orders or Refills.</p> <p>NOTE: The tier status of a Prescription Drug Product can change from time to time. These changes generally happen quarterly but no more than six times per calendar year, based on the PDL Management Committee's tiering decisions. When that happens, you may pay more or less for a Prescription Drug Product, depending on its tier placement. If the change involves the removal of a Prescription Drug Product or to a higher tier, we will provide you with 30 days' written notice before it becomes effective. Please contact us at www.myuhc.com or the telephone number on your ID card for the most up-to-date tier status.</p> <p>Coupons: We will not permit you to use certain coupons or offers from pharmaceutical manufacturers or an affiliate to reduce your Co-payment and/or Co-insurance. You may access information on which coupons or offers are not permitted by contacting us at www.myuhc.com or the telephone number on your ID card.</p>	

Benefit Information

<p>The amounts you are required to pay as shown below in the <i>Outpatient Prescription Drug Schedule of Benefits</i> are based on the Prescription Drug Charge.</p>	
<p>Description and Supply Limits</p>	<p>What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both</p>
<p>Specialty Prescription Drug Products</p>	
<p>The following supply limits apply.</p> <ul style="list-style-type: none"> • As written by the provider, up to a consecutive 30-day supply of a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits, or as allowed under the Smart Fill Program. • When a Specialty Prescription Drug Product is classified as a Maintenance Medication according to Maryland law and as confirmed by the provider: <ul style="list-style-type: none"> ▪ Up to a consecutive 30-day supply for a new prescription or a change in prescription of a Specialty Prescription Drug Product; and ▪ Thereafter, up to a consecutive 90-day supply of a Specialty Prescription Drug Product subject to a Co-payment and/or Co-insurance up to 2.5 times the Co-payment and/or Co-insurance for a 30-day supply. • When a Specialty Prescription Drug Product is a covered prescription eye drop medication, Benefits will be provided for early eye drop refills, in accordance with guidance for early refill of topical ophthalmic product provided to Medicare Part D plan sponsors by the Centers for Medicare and Medicaid; and if: 1) 	<p>Your Co-payment and/or Co-insurance is determined by the PDL Management Committee's tier placement of the Specialty Prescription Drug Product. All Specialty Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2, Tier 3 or Tier 4. Please contact us at www.myuhc.com or the telephone number on your ID card to find out tier placement.</p> <p>For a Tier 1 Specialty Prescription Drug Product: None of the Prescription Drug Charge after you pay \$5.00 per Prescription Order or Refill.</p> <p>However, you will not pay more than \$150 per 30-day supply for a Specialty Prescription Drug Product Prescription Order or Refill.</p> <p>For a Tier 2 Specialty Prescription Drug Product: None of the Prescription Drug Charge after you pay \$50.00 per Prescription Order or Refill.</p> <p>However, you will not pay more than \$150 per 30-day supply for a Specialty Prescription Drug Product Prescription Order or Refill.</p> <p>For a Tier 3 Specialty Prescription Drug Product: None of the Prescription Drug Charge after you pay \$100.00 per Prescription Order or Refill.</p> <p>However, you will not pay more than \$150 per 30-day supply for a Specialty Prescription Drug Product Prescription Order or Refill.</p> <p>For a Tier 4 Specialty Prescription Drug Product: None of the Prescription Drug Charge after you pay \$150.00 per Prescription Order or Refill.</p> <p>However, you will not pay more than \$150 per 30-day supply for a Specialty Prescription Drug Product Prescription Order or Refill.</p>

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge.

Description and Supply Limits	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both
<p>the prescribing Physician indicates on the original Prescription Order or Refill that additional quantities of the prescription eye drops are needed and; 2) the refill requested by the Covered Person does not exceed the number of additional quantities indicated on the original Prescription Order or Refill.</p> <p>When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 30-day supply or is classified as a Maintenance Medication, the Co-payment and/or Co-insurance that applies will reflect the number of days dispensed. However, you will not pay more than \$150 per 30-day supply for a Specialty Prescription Drug Product Prescription Order or Refill, no matter how long this supply actually lasts.</p> <p>If a Specialty Prescription Drug Product is provided for less than or more than a 30-day supply, the Co-payment and/or Co-insurance that applies will reflect the number of days dispensed.</p> <p>Supply limits apply to Specialty Prescription Drug Products obtained at a Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.</p>	
<p>Prescription Drugs from a Retail or Mail Order Network Pharmacy</p>	
<p>The following supply limits apply:</p> <ul style="list-style-type: none"> As written by the provider, up to a consecutive 30-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or 	<p>Your Co-payment and/or Co-insurance is determined by the PDL Management Committee's tier placement of the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2, Tier 3 or Tier 4. Please contact us at www.myuhc.com or the telephone number on your ID card to find out tier status.</p> <p>For a Tier 1 Prescription Drug Product: None of the</p>

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge.

Description and Supply Limits	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both
<p>based on supply limits.</p> <ul style="list-style-type: none"> • When a Prescription Drug Product is classified as a Maintenance Medication according to Maryland law and as written by the provider: <ul style="list-style-type: none"> ▪ Up to a consecutive 30-day supply for a new prescription or a change in prescription of a Prescription Drug Product; and ▪ Thereafter, up to a consecutive 90-day supply of a Prescription Drug Product subject to a Co-payment and/or Co-insurance up to 2.5 times the Co-payment and/or Co-insurance for a 30-day supply. • When a Prescription Drug Product is a covered prescription eye drop medication, Benefits will be provided for early eye drop refills, in accordance with guidance for early refill of topical ophthalmic product provided to Medicare Part D plan sponsors by the Centers for Medicare and Medicaid; and if: 1) the prescribing Physician indicates on the original Prescription Order or Refill that additional quantities of the prescription eye drops are needed and; 2) the refill requested by the Covered Person does not exceed the number of additional quantities indicated on the original Prescription Order or Refill. • A one-cycle supply of a contraceptive. You may obtain up to twelve cycles at one time. Each 	<p>Prescription Drug Charge after you pay \$5.00 per Prescription Order or Refill.</p> <p>For a Tier 2 Prescription Drug Product: None of the Prescription Drug Charge after you pay \$50.00 per Prescription Order or Refill.</p> <p>For a Tier 3 Prescription Drug Product: None of the Prescription Drug Charge after you pay \$100.00 per Prescription Order or Refill.</p> <p>For a Tier 4 Prescription Drug Product: None of the Prescription Drug Charge after you pay \$150.00 per Prescription Order or Refill.</p>

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge.

Description and Supply Limits	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both
<p>cycle is no less than a one-month's supply.</p> <p>Benefits include <i>FDA</i> approved contraceptive drugs or devices without a Co-payment or Co-insurance requirement when obtained under a prescription written by an authorized prescriber. However, a Co-payment or Co-insurance may apply for a contraceptive drug or device that, according to the <i>FDA</i> is therapeutically equivalent to another contraceptive drug or device that is available under your plan without a Co-payment or Co-insurance requirement.</p> <p>For contraceptives that have a member cost share, you will pay a Co-payment or Co-insurance for each cycle supplied.</p> <p>Co-payments or Co-insurance for <i>FDA</i> approved over-the-counter contraceptive drugs dispensed without a prescription and available by prescription or over-the-counter will not exceed the Co-payment or Co-insurance for the contraceptive drug when dispensed as a prescription.</p>	

Outpatient Prescription Drug Rider

UnitedHealthcare of the Mid-Atlantic, Inc.

This Rider to the Policy is issued to the Group and provides Benefits for Prescription Drug Products.

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in either the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms* or in this Rider in *Section 3: Defined Terms*.

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare of the Mid-Atlantic, Inc. When we use the words "you" and "your" we are referring to people who are Covered Persons, as the term is defined in the *Certificate* in *Section 9: Defined Terms*.

NOTE: The Coordination of Benefits provision in the *Certificate* in *Section 7: Coordination of Benefits* applies to Prescription Drug Products covered through this Rider. Benefits for Prescription Drug Products will be coordinated with those of any other health plan in the same manner as Benefits for Covered Health Care Services described in the *Certificate*.

UNITEDHEALTHCARE INSURANCE COMPANY

A handwritten signature in black ink, appearing to read 'Joe Ochipinti', written over a horizontal line.

Joseph A. Ochipinti, President and CEO

Introduction

Coverage Policies and Guidelines

Our Prescription Drug List (PDL) Management Committee makes tier placement changes on our behalf. The PDL Management Committee places *FDA*-approved Prescription Drug Product into tiers by considering a number of factors including clinical and economic factors. Clinical factors may include review of the place in therapy or use as compared to other similar product or services, site of care, relative safety or effectiveness of the Prescription Drug Product, as well as if certain supply limits or prior authorization requirements should apply. Economic factors may include the Prescription Drug Product's total cost including any rebates and evaluations of the cost effectiveness of the Prescription Drug Product.

We may, from time to time, change the placement of a Prescription Drug Product among the tiers. These changes generally will happen quarterly, but no more than six times per calendar year. These changes may happen without prior notice to you, except if the change involves the removal of a Prescription Drug Product or to a higher tier, we will provide you with 30 days' written notice before it becomes effective.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for you is a determination that is made by you and your prescribing Physician.

NOTE: The tier placement of a Prescription Drug Product may change, from time to time, based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please contact us at www.myuhc.com or the telephone number on your ID card for the most up-to-date tier placement.

Identification Card (ID Card) - Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by us during regular business hours.

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you must pay the Usual and Customary Charge for the Prescription Drug Product at the pharmacy.

You may seek reimbursement from us as described in the *Certificate* in *Section 5: How to File a Claim*. When you submit a claim on this basis, you may pay more because you did not verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Co-payment and/or Co-insurance, and any deductible that applies.

Submit your claim to:

Optum Rx

PO Box 29077

Hot Springs, AR 71903

Designated Pharmacies

If you require certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, no Benefit will be paid for that Prescription Drug Product, except when the Prescription Order or Refill is for an Emergency, or for an unforeseen illness, injury, or condition requiring immediate care.

Smart Fill Program - 90 Day Supply

Certain Specialty Prescription Drug Products may be dispensed by the Designated Pharmacy in 90-day supplies. The Co-payment and/or Co-insurance will reflect the number of days dispensed. The *Smart Fill Program* offers a 90 day supply of certain Specialty Prescription Drug Products if you are stabilized on a Specialty Prescription Drug Product included in the *Smart Fill Program*. You may find a list of Specialty Prescription Drug Products included in the *Smart Fill Program*, by contacting us at www.myuhc.com or the telephone number on your ID card.

When Do We Limit Selection of Pharmacies?

If we determine that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your choice of Network Pharmacies may be limited. If this happens, we may require you to choose one Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the chosen Network Pharmacy. If you don't make a choice within 31 days of the date we notify you, we will choose a Network Pharmacy for you.

Rebates and Other Payments

We may receive rebates for certain drugs included on the Prescription Drug List, including those drugs that you purchase prior to meeting any applicable deductible. A portion of these rebates will be applied to the calculation of your member cost share at the point-of-sale, resulting in either the same or lower cost share than you otherwise would pay.

We, and a number of our affiliated entities, conduct business with pharmaceutical manufacturers separate and apart from this *Outpatient Prescription Drug Rider*. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this *Outpatient Prescription Drug Rider*. We are not required to pass on to you, and do not pass on to you, such amounts.

Outpatient Prescription Drug Rider Table of Contents

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Section 1: Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy and are subject to Co-payments and/or Co-insurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is placed. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for applicable Co-payments and/or Co-insurance requirements.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Care Service or is prescribed to prevent conception.

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

If you require Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Specialty Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Specialty Prescription Drug Product from a Designated Pharmacy, no Benefit will be paid for that Specialty Prescription Drug Product, except when the Prescription Order or Refill is the result of an Emergency; or an unforeseen illness, injury, or condition requiring immediate care.

Please see *Section 3: Defined Terms* for a full description of Specialty Prescription Drug Product and Designated Pharmacy.

The *Outpatient Prescription Drug Schedule of Benefits* will tell you how Specialty Prescription Drug Product supply limits apply.

Prescription Drugs for Tobacco Cessation

In accordance with state law, Benefits for Prescription Drug Products are available for tobacco cessation when prescribed by an Authorized Prescriber for tobacco cessation treatment. This includes:

- Any Prescription Drug Product that is approved by the *U.S. Food and Drug Administration* as an aid for the cessation of the use of tobacco products; and
- Prescription Drug Products defined as Nicotine Replacement Therapy limited to two 90-day courses of treatment per calendar year.

Contraceptives Without a Prescription

Benefits are available for contraceptives dispensed without a prescription when they are approved by the *U.S. Food and Drug Administration (FDA)* and available by prescription and over-the-counter. Co-payments or Co-insurance for *FDA* approved over-the-counter contraceptive drugs dispensed without a prescription and available by prescription or over-the-counter will not exceed the Co-payment or Co-insurance for the contraceptive drug when dispensed as a prescription.

Partial Supply of a Prescription Drug Product

We will allow and apply a pro-rated daily Co-payment or Co-insurance amount for a partial supply of a Prescription Drug Product that is dispensed by a Network Pharmacy if:

- The prescriber or the pharmacist determines dispensing a partial supply of a Prescription Drug Product to be in your best interest;
- The Prescription Drug Product is anticipated to be required for more than 3 months;
- You request or agree to a partial supply for the purpose of synchronizing the dispensing of your Prescription Drug Products;

- The Prescription Drug Product is not a Schedule II controlled dangerous substance; and
- The supply and dispensing of the Prescription Drug Product meets all prior authorization and utilization management requirements specific to the Prescription Drug Product at the time of the synchronized dispensing.

Prescription Drugs from a Retail Network Pharmacy

Benefits are provided for Prescription Drug Products dispensed by a retail Network Pharmacy.

The *Outpatient Prescription Drug Schedule of Benefits* will tell you how retail Network Pharmacy supply limits apply.

Prescription Drug Products from a Mail Order Pharmacy

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Pharmacy.

The *Outpatient Prescription Drug Schedule of Benefits* will tell you how mail order Pharmacy supply limits apply.

Please contact us at www.myuhc.com or the telephone number on your ID card to find out if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order Pharmacy.

Section 2: Exclusions

Exclusions from coverage listed in the *Certificate* also apply to this Rider. In addition, the exclusions listed below apply.

When an exclusion applies to only certain Prescription Drug Products, you can contact us at www.myuhc.com or the telephone number on your ID card for information on which Prescription Drug Products are excluded.

1. Outpatient Prescription Drug Products obtained from an out-of-Network Pharmacy, except as a result of:
 - An Emergency; or
 - An unforeseen illness, injury, or condition requiring immediate care.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
3. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit required to treat the particular condition. This exclusion does not apply to the off-label use of a Prescription Drug Product as mandated by Maryland Insurance Code §15-804. This exclusion also does not apply to the section above titled "Partial Supply of a Prescription Drug Product."
4. Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
5. Drugs that are prescribed, dispensed or intended for use during an Inpatient Stay.
6. Experimental or Investigational or Unproven Services and medications; medications used for experimental treatments for specific diseases and/or dosage regimens determined by us to be experimental, investigational or unproven. This exclusion does not apply to the off-label use of a Prescription Drug Product if such Prescription Drug Product is recognized for treatment in any of the standard reference compendia or in the medical literature. Furthermore we shall provide Benefits for Prescription Drug Products that have been approved for sale by the *U.S. Food and Drug Administration (FDA)* whether or not the *FDA* has approved the Prescription Drug Product for use in treatment a particular condition, to the extent that the Prescription Drug Products are not paid for by the manufacturer, distributor, or provider of that Prescription Drug Product.
7. Prescription Drug Products furnished by the local, state or federal government. This exclusion does not apply to services provided or rendered under state medical assistance.
8. Prescription Drug Products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
9. Any product dispensed for the purpose of appetite suppression or weight loss.
10. A Pharmaceutical Product for which Benefits are provided in your *Certificate*. This includes all forms of vaccines/immunizations. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception as defined in *Section 3* under Prescription Drug Product.
11. Durable Medical Equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your *Certificate*. Prescribed and non-prescribed outpatient supplies. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.

12. General vitamins, except the following, which require a Prescription Order or Refill:
 - Prenatal vitamins.
 - Vitamins with fluoride.
 - Single entity vitamins.
13. Prescription Drug Products that are packaged in such a way that one package contains a single dose of medication. Exceptions to this exclusion are made if a Prescription Drug Product is available only in single dose packaging (i.e., unit dose). Prescription Drug Products which have been removed from its original manufacturer container and placed into a different container without any manipulation (i.e., repackaged).
14. Medications used solely for cosmetic purposes.
15. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Care Service, as defined in *Section 9: Defined Terms* of the *Certificate of Coverage*.
16. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
17. Prescription Drug Products when prescribed to treat infertility. Notwithstanding this exclusion, if in vitro fertilization is a Covered Health Care Service under the medical Benefits, and the procedure has been authorized, Prescription Drug Products associated with this procedure are also Covered Health Care Services.
18. Treatment for toenail Onychomycosis (toenail fungus).
19. Prescription Drug Products not placed on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List at the time the Prescription Order or Refill is dispensed. We have developed a process for evaluating Benefits for a Prescription Drug Product that is not on an available tier of the Prescription Drug List, but that has been prescribed as a Medically Necessary and appropriate alternative. For information about this process, contact the telephone number on your ID card.

However, we will provide immediate coverage for a Prescription Drug Product if, in the judgment of the Authorized Prescriber:

- There is no equivalent Prescription Drug Product on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List; or
 - An equivalent Prescription Drug Products on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List:
 - ◆ Has been ineffective in treating the Covered Person's disease or condition; or
 - ◆ Has caused or is likely to cause an adverse reaction or other harm to the Covered Persons; or
 - ◆ For a contraceptive prescription drug or device, the prescription drug or device that is not on the formulary is Medically Necessary for the Covered Person to adhere to the appropriate use of the prescription drug or device.
20. Any prescription medication that must be compounded into its final form by the dispensing pharmacist, Physician, or other health care provider.

However, we will provide immediate coverage for a compounded Prescription Drug Product if, in the judgment of the Authorized Prescriber:

- There is no equivalent Prescription Drug Products on the Prescription Drug List; or

- An equivalent Prescription Drug Product on the Prescription Drug List:
 - ◆ Has been ineffective in treating a Covered Person's disease or condition; or
 - ◆ Has caused or is likely to cause an adverse reaction or other harm to the Covered Person; or
 - ◆ For a contraceptive prescription drug or device, the prescription drug or device that is not on the formulary is Medically Necessary for the Covered Person to adhere to the appropriate use of the prescription drug or device.

21. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or made up of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that we have determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision. If the change involves the removal of a Prescription Drug Product or to a higher tier, we will provide you with 30 days' written notice before it becomes effective. This exclusion does not apply to over-the-counter contraceptives that do not require a prescription. This exclusion does not apply to over-the-counter drugs used for tobacco cessation. Please access www.myuhc.com through the Internet or call the telephone number on your ID card for information on which over-the-counter drugs are excluded.

Note: Notwithstanding this exclusion, we will provide immediate coverage for excluded Prescription Drug Products described above if, in the judgment of the Authorized Prescriber:

- The over-the-counter drug is not equivalent to the Prescription Drug Product on the Prescription Drug List; or
- An equivalent over-the-counter drug:
 - ◆ Has been ineffective in treating a Covered Person's disease or condition; or
 - ◆ Has caused or is likely to cause an adverse reaction or other harm to the Covered Person; or
 - ◆ For a contraceptive prescription drug or device, the prescription drug or device that is not on the formulary is Medically Necessary for the Covered Person to adhere to the appropriate use of the prescription drug or device.

22. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by our PDL Management Committee. However, we will provide immediate coverage for a New Prescription Drug Product if, in the judgment of the Authorized Prescriber:

- There is no equivalent Prescription Drug Product on the Prescription Drug List; or
- An equivalent Prescription Drug Product on the Prescription Drug List:
 - ◆ Has been ineffective in treating a Covered Person's disease or condition; or
 - ◆ Has caused or is likely to cause an adverse reaction or other harm to the Covered Person; or
 - ◆ For a contraceptive prescription drug or device, the prescription drug or device that is not on the formulary is Medically Necessary for the Covered Person to adhere to the appropriate use of the prescription drug or device.

23. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
24. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of Sickness or Injury, except as described in the *Certificate of Coverage, Section 1 Medical Foods and Amino Acid-Based Elemental Formula*.
25. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision. If the change involves the removal of a Prescription Drug Product or to a higher tier, we will provide you with 30 days' written notice before it becomes effective. Please access www.myuhc.com through the Internet or call the telephone number on your ID card for information on which Prescription Drug Products classified as Therapeutic Equivalent.

Note: We will provide immediate coverage for a Prescription Drug Product deemed Therapeutically Equivalent if, in the judgment of the Authorized Prescriber:

- The excluded Prescription Drug Product is not Therapeutically Equivalent to the other covered Prescription Drug Product; or
 - The covered Prescription Drug Product on the Prescription Drug List:
 - ◆ Has been ineffective in treating a Covered Person's disease or condition; or
 - ◆ Has caused or is likely to cause an adverse reaction or other harm to the Covered Person; or
 - ◆ For a contraceptive prescription drug or device, the prescription drug or device that is not on the formulary is Medically Necessary for the Covered Person to adhere to the appropriate use of the prescription drug or device.
26. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision. If the change involves the removal of a Prescription Drug Product or to a higher tier, we will provide you with 30 days' written notice before it becomes effective. Please access www.myuhc.com through the Internet or call the telephone number on your ID card for information on which Prescription Drug Products classified as Therapeutic Equivalent.

Note: We will provide immediate coverage for a Prescription Drug Product deemed Therapeutically Equivalent if, in the judgment of the Authorized Prescriber:

- The excluded Prescription Drug Product is not Therapeutically Equivalent to the other covered Prescription Drug Product; or
 - The covered Prescription Drug Product on the Prescription Drug List:
 - ◆ Has been ineffective in treating a Covered Person's disease or condition; or
 - ◆ Has caused or is likely to cause an adverse reaction or other harm to the Covered Person; or
 - ◆ For a contraceptive prescription drug or device, the prescription drug or device that is not on the formulary is Medically Necessary for the Covered Person to adhere to the appropriate use of the prescription drug or device.
27. A Prescription Drug Product that contains marijuana, including medical marijuana.

28. Dental products, except for fluoride supplements in accordance with the A or B service rating recommendations of the U.S. Preventive Services Task Force.
29. A Prescription Drug Product with either:
 - An approved biosimilar.
 - A biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product.

For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on both of the following:

- It is highly similar to a reference product (a biological Prescription Drug Product).
- It has no clinically meaningful differences in terms of safety and effectiveness from the reference product.

Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision. If the change involves the removal of a Prescription Drug Product or to a higher tier, we will provide you with 30 days' written notice before it becomes effective. However, we will provide immediate coverage for a biosimilar or a biosimilar and therapeutically equivalent if, in the judgment of the Authorized Prescriber (as defined in *Section 12-101 of the Health Occupation Article of the Maryland Code*):

- The excluded biosimilar or a biosimilar and therapeutically equivalent is not therapeutically equivalent to the other covered Prescription Drug Products; or
 - The covered biosimilar or a biosimilar and therapeutically equivalent on the Prescription Drug List:
 - ◆ Has been ineffective in treating a Covered Person's disease or condition; or
 - ◆ Has caused or is likely to cause an adverse reaction or other harm to the Covered Person; or
 - ◆ For a contraceptive prescription drug or device, the prescription drug or device that is not on the formulary is Medically Necessary for the Covered Person to adhere to the appropriate use of the prescription drug or device.
30. Diagnostic kits and products. This exclusion includes products/agents used to help diagnose a condition. These may be covered through the medical benefit. Examples include barium, drug assay test kits, DNA collection kits, and urine collection kits.
 31. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.
 32. Certain Prescription Drug Products that are *FDA* approved as a package with a device or application, including smart package sensors and/or embedded drug sensors, for convenience. This exclusion only applies to Prescription Drug Products that have covered Therapeutic Equivalents. This exclusion does not apply to a device or application that assists you with the administration of a Prescription Drug Product.

Section 3: Defined Terms

Annual Drug Deductible - the amount you must incur for covered Tier 3 and Tier 4 Prescription Drug Products in a year before becoming eligible for Prescription Drug Benefits. The *Outpatient Prescription Drug Schedule of Benefits* will tell you how the Annual Drug Deductible applies.

Authorized Prescriber - has the meaning stated in *Section 12-101* of the *Health Occupation Article* of the *Maryland Code*.

Brand-name - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that we identify as a Brand-name product, based on available data resources. This includes data sources such as Medi-Span, that classify drugs as either brand or generic based on a number of factors. Not all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician will be classified as Brand-name by us.

Chemically Equivalent - when Prescription Drug Products contain the same active ingredient.

Complex or Chronic Medical Condition - a physical, behavioral or developmental condition that may have no known cure, is progressive or can be debilitating or fatal if left untreated or undertreated. Complex or chronic medical condition includes multiple sclerosis, hepatitis C and rheumatoid arthritis.

Designated Pharmacy - a pharmacy that has entered into an agreement with us or with an organization contracting on our behalf, to provide specific Prescription Drug Products. This includes Specialty Prescription Drug Products. Not all Network Pharmacies are Designated Pharmacies.

Generic - a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that we identify as a Generic product based on available data resources. This includes, data sources such as Medi-Span, that classify drugs as either brand or generic based on a number of factors. Not all products identified as a "generic" by the manufacturer, pharmacy or your Physician will be classified as a Generic by us.

Maintenance Medication - a Prescription Drug Product anticipated to be used for six months or more to treat a chronic condition. You may find out if a Prescription Drug Product is a Maintenance Medication by contacting us at www.myuhc.com or the telephone number on your ID card.

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with us or an organization contracting on our behalf to provide Prescription Drug Products to Covered Persons; and
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products; and
- Been designated by us as a Network Pharmacy.

New Prescription Drug Product - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

- The date it is placed on a tier by our PDL Management Committee.
- December 31st of the following calendar year.

Nicotine Replacement Therapy - a Prescription Drug Product that:

- Is used to deliver nicotine to an individual attempting to cease the use of tobacco products;
- Is obtained under a prescription written by an Authorized Prescriber; and
- Does not include any over-the-counter product that may be obtained without a prescription.

PPACA - Patient Protection and Affordable Care Act of 2010.

PPACA Zero Cost Share Preventive Care Medications - the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Co-payment, Co-insurance, Annual Deductible, Annual Drug Deductible or Specialty Prescription Drug Product Annual Deductible) as required by applicable law under any of the following:

- 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*.
- 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.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

You may find out if a drug is a PPACA Zero Cost Share Preventive Care Medication as well as information on access to coverage of Medically Necessary alternatives by contacting us at www.myuhc.com or the telephone number on your ID card.

Prescription Drug Charge - the rate we have agreed to pay our Network Pharmacies for a Prescription Drug Product dispensed at a Network Pharmacy. The rate includes any applicable dispensing fee and sales tax.

Prescription Drug List - a list that places into tiers medications or products that have been approved by the *U.S. Food and Drug Administration (FDA)*. This list is subject to our review and change from time to time. You may find out to which tier a particular Prescription Drug Product has been placed by contacting us at www.myuhc.com or the telephone number on your ID card.

Prescription Drug List (PDL) Management Committee - the committee that we designate for placing Prescription Drug Products into specific tiers.

Prescription Drug Product - a medication or product that has been approved by the *U.S. Food and Drug Administration (FDA)* and that can, under federal or state law, be dispensed only according to a Prescription Order or Refill. A Prescription Drug Product includes a medication that is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the Policy, this definition includes:

- Inhalers (with spacers).
- Insulin.
- Vaccines/immunizations administered in a Network Pharmacy.
- The following diabetic supplies:
 - standard insulin syringes with needles;
 - blood-testing strips - glucose;
 - urine-testing strips - glucose;
 - ketone-testing strips and tablets;
 - lancets and lancet devices; and
 - glucose meters including continuous glucose monitors.

- In accordance with Maryland law, medical foods and low protein modified food products when prescribed and administered under the direction of a Physician for the treatment of inherited metabolic diseases caused by an inherited abnormality of body chemistry. See *Medical Foods in Section 1: Covered Health Care Services* in your *Certificate of Coverage* for more information.
- Contraceptive drugs or devices that are approved by the *U.S. Food and Drug Administration (FDA)* for use as a contraceptive and that are obtained under a prescription written by an Authorized Prescriber as defined in *Section 12-101* of the *Maryland Health Occupations Article* or obtained without a prescription as described under *Contraceptives Without a Prescription* above in *Section 1: Benefits for Prescription Drug Products*.

Prescription Order or Refill - the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice allows issuing such a directive.

Rare Medical Condition - a disease or condition that affects fewer than 200,000 individuals in the United States or approximately 1 in 1,500 individuals worldwide. Rare Medical Condition includes: cystic fibrosis, hemophilia and multiple myeloma.

Specialty Prescription Drug Product - are prescribed for an individual with a complex or chronic medical condition or a rare medical condition that costs \$600 or more for up to a 30-day supply, is not typically stocked at retail pharmacies and requires a difficult or unusual process of delivery to the patient in the preparation, handling, storage, inventory, or distribution of the drug. These drug products require enhanced patient education, management, or support, beyond those required for traditional dispensing, before or after administration of the drug. Specialty Prescription Drug Products do not include drugs prescribed to treat diabetes, HIV or AIDS.

Standard Reference Compendia - any authoritative compendia as recognized periodically by the federal Secretary of *Health and Human Services* or the Maryland Commissioner.

Therapeutic Class - a group or category of Prescription Drug Products with similar uses and/or actions.

Therapeutically Equivalent - when Prescription Drug Products have essentially the same efficacy and adverse effect profile.

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. This fee includes any applicable dispensing fee and sales tax.

Real Appeal Rider

UnitedHealthcare of the Mid-Atlantic, Inc.

This Rider to the Policy provides Benefits for virtual obesity counseling services for eligible Covered Persons through Real Appeal. There are no deductibles, Co-payments or Co-insurance you must meet or pay for when receiving these services.

Real Appeal

Real Appeal provides a virtual lifestyle intervention for weight-related conditions to eligible Covered Persons 13 years of age or older and who do not have a medical condition that would exclude them from participating. The following are not eligible to participate:

- Age 12 or younger
- Anorexia or Bulimia Nervosa (present or recent history)
- BMI less than 19
- Pregnant or nursing an infant, unless your physician has agreed Real Appeal is appropriate for you.
- Severe liver, heart, kidney, neurologic, psychiatric or any severe chronic or acute illness, unless your physician has agreed Real Appeal is appropriate for you.

Real Appeal is designed to help those at risk from obesity-related diseases.

This intensive, multi-component behavioral intervention provides 52 weeks of support. This support includes one-on-one coaching with a live virtual coach and online group participation with supporting video content. The experience will be personalized for each individual through an introductory online session.

These Covered Health Care Services will be individualized and include the following:

- Virtual support and self-help tools: Personal one-on-one coaching, group support sessions, educational videos, tailored kits, integrated web platform and mobile applications.
- Education and training materials focused on goal setting, problem-solving skills, barriers and strategies to maintain changes.
- Behavioral change counseling by a specially trained coach for clinical weight loss.

If you would like information regarding these Covered Health Care Services, you may contact us through www.realappeal.com, <https://member.realappeal.com> or at the number shown on your ID card.

UNITEDHEALTHCARE INSURANCE COMPANY



Joseph A. Ochipinti, President and CEO

SanvelloSM Self Help Tool Rider

UnitedHealthcare of the Mid-Atlantic, Inc.

This Rider to the Policy describes a self-help tool available to eligible Covered Persons.

Because this Rider is part of a legal document (the Group Policy), we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms*.

Sanvello provides digital support techniques designed to help you relax, shift perspectives or cope with stressful situations.

Sanvello provides tools and support, such as:

- Mood and health data tracking over time.
- Integrated goal-setting and progress assessments.
- Relaxation techniques.

Sanvello can be accessed through the following links www.myuhc.com or www.liveandworkwell.com, by downloading the Sanvello application on your mobile device or through www.Sanvello.com.

UNITEDHEALTHCARE INSURANCE COMPANY

A handwritten signature in black ink, appearing to read 'Joe Ochipinti', with a long horizontal flourish extending to the right.

Joseph A. Ochipinti, President and CEO

Language Assistance Services

We¹ provide free language services to help you communicate with us. We offer interpreters, letters in other languages, and letters in other formats like large print. To get help, please call 1-866-633-2446, or the toll-free member phone number listed on your health plan ID card, TTY/RTT 711. We are available Monday through Friday, 8 a.m. to 8 p.m. ET.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-866-633-2446.

請注意：如果您說中文 (**Chinese**)，我們免費為您提供語言協助服務。請致電：1-866-633-2446。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi 1-866-633-2446.

알림: 한국어(**Korean**)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-633-2446 번으로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Mangyaring tumawag sa 1-866-633-2446.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **Русский (Russian)**. Позвоните по номеру 1-866-633-2446.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال بـ 1-866-633-2446.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nan 1-866-633-2446.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le 1-866-633-2446.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod numer 1-866-633-2446.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para 1-866-633-2446.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero 1-866-633-2446.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie 1-866-633-2446 an.

注意事項：日本語 (**Japanese**) を話される場合、無料の言語支援サービスをご利用いただけます。1-866-633-2446 にお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. 1-866-633-2446 تماس بگیرید.

कृपा ध्यान दें: यदि आप **हिंदी (Hindi)** भाषी हैं तो आपके लिए भाषा सहायता सेवाएं निःशुल्क उपलब्ध हैं। कृपा पर काल करें 1-866-633-2446

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau 1-866-633-2446.

ចំណាប់អារម្មណ៍: បើសិនជាអ្នកនិយាយ **ភាសាខ្មែរ (Khmer)** សេវាជំនួយភាសាដោយគេគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខ 1-866-633-2446។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyan. Maidawat nga awagan iti 1-866-633-2446.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yánit'i'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shoodí kohjí' 1-866-633-2446 hodiilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac 1-866-633-2446.

ΠΡΟΣΟΧΗ: Αν μιλάτε **Ελληνικά (Greek)**, υπάρχει δωρεάν βοήθεια στη γλώσσα σας. Παρακαλείστε να καλέσετε 1-866-633-2446. ¶

¶

ध्यान आपो: જો તમે **ગુજરાતી (Gujarati)** બોલતા છો તો આપને ભાષાકીય મદદરૂપ સેવા ¶
વિના મૂલ્યે પ્રાપ્ય છે. ¶

કૃપા કરી 1-866-633-2446 પર કોલ કરો. ¶

Notice of Non-Discrimination

We¹ do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UTAH 84130
UHC_Civil_Rights@uhc.com

You must send the complaint within 60 days of the incident. We will send you a decision within 30 days. If you disagree with the decision, you have 15 days to appeal.

If you need help with your complaint, please call 1-866-633-2446 or the toll-free member phone number listed on your health plan ID card, TTY/RTT 711. We are available Monday through Friday, 8 a.m. to 8 p.m. ET

You can also file a complaint with the U.S. Dept. of Health and Human services.

Online: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Phone: Toll-free 1-800-368-1019, 1-800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

¹For purposes of the Language Assistance Services and this Non-Discrimination Notice ("Notice"), "we" refers to the entities listed in Footnote 2 of the Notice of Privacy Practices and Footnote 3 of the Financial Information Privacy Notice. Please note that not all entities listed are covered by this Notice.

Important Notices

Women's Health and Cancer Rights Act of 1998

As required by the *Women's Health and Cancer Rights Act of 1998*, Benefits under the Policy are provided for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Care Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Care Services (including Co-payments, Co-insurance and any deductible) are the same as are required for any other Covered Health Care Service. Limitations on Benefits are the same as for any other Covered Health Care Service.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g. your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain prior authorization. For information on prior authorization, contact your issuer.

Notice of Transition of Care

As required by the *No Surprises Act of the Consolidated Appropriations Act (P.L. 116-260)*, group health plans must provide Benefits for transition of care. If you are currently undergoing a course of treatment with a Physician or health care facility that is out-of-Network under this new plan, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help to find out if you are eligible for transition of care Benefits, please call the telephone number on your ID card.

Claims and Appeal Notice

This Notice is provided to you in order to describe our responsibilities under Federal law for making benefit determinations and your right to appeal adverse benefit determinations. To the extent that state law provides you with more generous timelines or opportunities for appeal, those rights also apply to you. Please refer to your benefit documents for information about your rights under state law.

Benefit Determinations

Post-service Claims

Post-service claims are those claims that are filed for payment of Benefits after medical care has been received. If your post-service claim is denied, you will receive a written notice from us within 30 days of receipt of the claim, as long as all needed information was provided with the claim. We will notify you within this 30 day period if additional information is needed to process the claim, and may request a one-time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, and the claim is denied, we will notify you of the denial within 30 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 explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

If you have prescription drug Benefits and are asked to pay the full cost of a prescription when you fill it at a retail or mail-order pharmacy, and if you believe that it should have been paid under the Policy, you may submit a claim for reimbursement according to the applicable claim filing procedures. If you pay a Co-payment and believe that the amount of the Co-payment was incorrect, you also may submit a claim for reimbursement according to the applicable claim filing procedures. When you have filed a claim, your claim will be treated under the same procedures for post-service group health plan claims as described in this section.

Pre-service Requests for Benefits

Pre-service requests for Benefits are those requests that require notification or approval prior to receiving medical care. If you have a pre-service request for Benefits, and it was submitted properly with all needed information, we will send you written notice of the decision from us within 15 days of receipt of the request. If you filed a pre-service request for Benefits improperly, we will notify you of the improper filing and how to correct it within five days after the pre-service request for Benefits was received. If additional information is needed to process the pre-service request, we will notify you of the information needed within 15 days after it was received, and may request a one-time extension not longer than 15 days and pend your request until all information is received. Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, we will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your request for Benefits will be denied. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the appeal procedures.

If you have prescription drug Benefits and a retail or mail order pharmacy fails to fill a prescription that you have presented, you may file a pre-service health request for Benefits according to the applicable claim filing procedure. When you have filed a request for Benefits, your request will be treated under the same procedures for pre-service group health plan requests for Benefits as described in this section.

Urgent Requests for Benefits that Require Immediate Attention

Urgent requests for Benefits are those that require notification or a benefit determination prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health, or the ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, could cause severe pain. In these situations, you will receive notice of the benefit determination in writing or electronically within 72 hours after we receive all necessary information, taking into account the seriousness of your condition.

If you filed an urgent request for Benefits improperly, we will notify you of the improper filing and how to correct it within 24 hours after the urgent request was received. If additional information is needed to process the request, we will notify you of the information needed within 24 hours after the request was received. You then have 48 hours to provide the requested information.

You will be notified of a benefit determination no later than 48 hours after:

- Our receipt of the requested information.
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. We will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Questions or Concerns about Benefit Determinations

If you have a question or concern about a benefit determination, you may informally call us at the telephone number on your ID card before requesting a formal appeal. If the representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described above, you may appeal it as described below, without first informally contacting a representative. If you first informally contact us and later wish to request a formal appeal in writing, you should again contact us and request an appeal. If you request a formal appeal, a representative will provide you with the appropriate address.

If you are appealing an urgent claim denial, please refer to *Urgent Appeals that Require Immediate Action* below and contact us immediately.

How Do You Appeal a Claim Decision?

If you disagree with a pre-service request for Benefits determination or post-service claim determination or a rescission of coverage determination after following the above steps, you can contact us in writing to formally request an appeal.

Your request for an appeal should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to us within 180 days after you receive the denial of pre-service request for benefits or a claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be chosen to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with expertise in the field, who was not involved in the prior determination. We may consult with, or ask medical experts to take part in the appeal process. You consent to this referral and the sharing of needed medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information related to your claim for Benefits. If any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge in advance of the due date of the response to the adverse benefit determination.

Appeals Determinations

Pre-service Requests for Benefits and Post-service Claim Appeals

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of pre-service requests for Benefits as shown above, the first level appeal will take place and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied request for Benefits. However, if your state requires two levels of appeal, the first level appeal will take place and you will be notified of the decision within 15 days.

If your state requires a second level appeal, it must be submitted to us within 60 days from receipt of the first level appeal decision. The second level appeal will take place and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.

- For appeals of post-service claims as shown above, the first level appeal will take place and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. However, if your state requires two levels of appeal, the first level appeal will take place and you will be notified of the decision within 30 days.

If your state requires a second level appeal, it must be submitted to us within 60 days from the receipt of the first level appeal decision. The second level appeal will take place and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures related to urgent requests for Benefits, see *Urgent Appeals that Require Immediate Action* below.

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure. The decision to obtain the proposed treatment or procedure regardless of our decision is between you and your Physician.

Urgent Appeals that Require Immediate Action

Your appeal may require urgent action if a delay in treatment could increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.
- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If we need more information from your Physician to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.

The appeal process for urgent situations does not apply to prescheduled treatments, therapies, or surgeries.

HEALTH PLAN NOTICES OF PRIVACY PRACTICES

MEDICAL INFORMATION PRIVACY NOTICE

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.

Effective January 1, 2022:

We² are required by law to protect the privacy of your health information. We are also required to send you this notice, which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice. We are required by law to abide by the terms of this notice.

The terms "information" or "health information" in this notice include any information we maintain that reasonably can be used to identify you and that relates to your physical or mental health care condition, the provision of health care to you, or the payment for such health care. We will comply with the requirements of applicable privacy laws related to notifying you in the event of a breach of your health information.

We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, we will provide to you, in our next annual distribution, either a revised notice or information about the material change and how to obtain a revised notice. We will provide you with this information either by direct mail or electronically, in accordance with applicable law. In all cases, if we maintain a website for your particular health plan, we will post the revised notice on your health plan website, such as www.myuhc.com. We have the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

UnitedHealth Group collects and maintains oral, written and electronic information to administer our business and to provide products, services and information of importance to our enrollees. We maintain physical, electronic and procedural security safeguards in the handling and maintenance of our enrollees' information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction or misuse.

How We Collect, Use, and Disclose Information

We collect, use, and disclose your health information to provide that information:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice.
- To the *Secretary of the Department of Health and Human Services*, if necessary, to make sure your privacy is protected.

We have the right to collect, use, and disclose health information for your treatment, to pay for your health care and to operate our business. For example, we may use or disclose your health information:

- **For Payment** of premiums due us, to determine your coverage, and to process claims for health care services you receive, including for subrogation or coordination of other benefits you may have. For example, we may tell a doctor whether you are eligible for coverage and what percentage of the bill may be covered.
- **For Treatment.** We may collect, use, and disclose health information to aid in your treatment or the coordination of your care. For example, we may collect information from, or disclose information to your physicians or hospitals to help them provide medical care to you.

- **For Health Care Operations.** We may collect, use, and disclose health information needed to operate and manage our business activities related to providing and managing your health care coverage. For example, we might talk to your physician to suggest a disease management or wellness program that could help improve your health or we may analyze data to determine how we can improve our services. We may also de-identify health information in accordance with applicable laws. After that information is de-identified, the information is no longer subject to this notice and we may use the information for any lawful purpose.
- **To Provide You Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law.
- **For Plan Sponsors.** If your coverage is through an employer sponsored group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration purposes if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with federal law.
- **For Underwriting Purposes.** We may collect, use, and disclose your health information for underwriting purposes; however, we will not use or disclose your genetic information for such purposes.
- **For Reminders.** We may use or disclose health information to send you reminders about your benefits or care, such as appointment reminders with providers who provide medical care to you.
- **For Communications to You.** We may communicate, electronically or via telephone, these treatment, payment or health care operation messages using telephone numbers or email addresses you provide to us.

We may collect, use, and disclose your health information for the following purposes under limited circumstances:

- **As Required by Law.** We may disclose information when required to do so by law.
- **To Persons Involved With Your Care.** We may collect, use, and disclose your health information to a person involved in your care or who helps pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interests. Special rules apply regarding when we may disclose health information to family members and others involved in a deceased individual's care. We may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.
- **For Public Health Activities** such as reporting or preventing disease outbreaks to a public health authority.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social service or protective service agency.
- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.

- **For Law Enforcement Purposes.** We may disclose your health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.
- **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public, by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers' Compensation** as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.
- **For Research Purposes** such as research related to the review of certain treatments or the prevention of disease or disability, if the research study meets federal privacy law requirements.
- **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as needed to carry out their duties.
- **For Organ Procurement Purposes.** We may collect, use, and disclose information to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if needed (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **To Business Associates** that perform functions on our behalf or provide us with services if the information is needed for such functions or services. Our business associates are required, under contract with us, and according to federal law, to protect the privacy of your information and are not allowed to collect, use, and disclose any information other than as shown in our contract and as permitted by federal law.
- **Additional Restrictions on Use and Disclosure.** Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. Such laws may protect the following types of information:
 1. Alcohol and Substance Abuse
 2. Biometric Information
 3. Child or Adult Abuse or Neglect, including Sexual Assault
 4. Communicable Diseases
 5. Genetic Information
 6. HIV/AIDS
 7. Mental Health
 8. Minors' Information
 9. Prescriptions
 10. Reproductive Health

11. Sexually Transmitted Diseases

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

Except for uses and disclosures described and limited as stated in this notice, we will use and disclose your health information only with a written authorization from you. This includes, except for limited circumstances allowed by federal privacy law, not using or disclosing psychotherapy notes about you, selling your health information to others, or using or disclosing your health information for certain promotional communications that are prohibited marketing communications under federal law, without your written authorization. Once you give us authorization to release your health information, we cannot guarantee that the recipient to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. To find out where to mail your written authorization and how to revoke an authorization, call the phone number listed on your health plan ID card.

What Are Your Rights

The following are your rights with respect to your health information:

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that authorize your dependents to request certain restrictions. **Please note that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any restriction.**
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests where a disclosure of all or part of your health information otherwise could endanger you. In certain circumstances, we will accept your verbal request to receive confidential communications, however; we may also require you confirm your request in writing. In addition, any requests to change or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.
- **You have the right to see and get a copy** of certain health information we maintain about you such as claims and case or medical management records. If we maintain your health information electronically, you will have the right to request that we send a copy of your health information in an electronic format to you. You can also request that we provide a copy of your information to a third party that you identify. In some cases, you may receive a summary of this health information. You must make a written request to inspect and copy your health information or have your information sent to a third party. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information. If we deny your request, you may have the right to have the denial reviewed. We may charge a reasonable fee for any copies.
- **You have the right to ask to amend** certain health information we maintain about you such as claims and case or medical management records, if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to receive an accounting** of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) for treatment, payment, and health care operations purposes; (ii) to you or according to your authorization; and (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require us to provide an accounting.

- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You also may get a copy of this notice on your health plan website, such as www.myuhc.com.
- **You have the right to make a written request that we correct or amend** your personal information. Depending on your state of domicile, you may have the right to request the deletion of your personal information. If we are unable to honor your request, we will notify you of our decision. If we deny your request, you have the right to submit to us a written statement of the reasons for your disagreement with our assessment of the disputed information and what you consider to be the correct information. We will make your statement accessible to parties reviewing the information in dispute.

Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want information about exercising your rights, please call the toll-free member phone number on your health plan ID card or you may call us at 1-866-633-2446 or TTY 711.
- **Submitting a Written Request.** You can mail your written requests to exercise any of your rights, including modifying or cancelling a confidential communication, for copies of your records, or requesting amendments to your record, to us at the following address:

UnitedHealthcare
Customer Service - Privacy Unit
 PO Box 740815
 Atlanta, GA 30374-0815

- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the address listed above.

You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. We will not take any action against you for filing a complaint.

²This Medical Information Notice of Privacy Practices applies to the following health plans that are affiliated with UnitedHealth Group: ACN Group of California, Inc.; All Savers Insurance Company; All Savers Life Insurance Company of California; AmeriChoice of New Jersey, Inc.; Arizona Physicians IPA, Inc.; Care Improvement Plus of Texas Insurance Company; Care Improvement Plus South Central Insurance Company; Care Improvement Plus Wisconsin Insurance Company; Dental Benefit Providers of California, Inc.; Dental Benefit Providers of Illinois, Inc.; Enterprise Life Insurance Company; Freedom Life Insurance Company of America; Golden Rule Insurance Company; Health Plan of Nevada, Inc.; MAMSI Life and Health Insurance Company; March Vision Care, Inc.; MD - Individual Practice Association, Inc.; Medical Health Plans of Florida, Inc.; Medica HealthCare Plans, Inc.; National Pacific Dental, Inc.; National Foundation Life Insurance Company; Neighborhood Health Partnership, Inc.; Nevada Pacific Dental; Optimum Choice, Inc.; Optum Insurance Company of Ohio, Inc.; Oxford Health Insurance, Inc.; Oxford Health Plans (CT), Inc.; Oxford Health Plans (NJ), Inc.; Oxford Health Plans (NY), Inc.; PacifiCare Life and Health Insurance Company; PacifiCare Life Assurance Company; PacifiCare of Arizona, Inc.; PacifiCare of Colorado, Inc.; PacifiCare of Nevada, Inc.; Physicians Health Choice of Texas, LLC; Preferred Care Partners, Inc.; Rocky Mountain Health Maintenance Organization, Incorporated; Sierra Health and Life Insurance Company, Inc.; UHC of California; U.S. Behavioral Health Plan, California; Unimerica Insurance Company; Unimerica Life Insurance Company of New York; Unison Health Plan of Delaware, Inc.; UnitedHealthcare Benefits of Texas, Inc.; UnitedHealthcare Community Plan of California, Inc.; UnitedHealthcare Community Plan of Georgia, Inc.; UnitedHealthcare Community Plan of Ohio, Inc.; UnitedHealthcare Community Plan, Inc.; UnitedHealthcare Community Plan of Texas, L.L.C.; UnitedHealthcare Insurance Company; UnitedHealthcare Insurance Company of America;

UnitedHealthcare Insurance Company of Illinois; UnitedHealthcare Insurance Company of New York; UnitedHealthcare Insurance Company of the River Valley; UnitedHealthcare Integrated Services, Inc; UnitedHealthcare Life Insurance Company; UnitedHealthcare of Alabama, Inc.; UnitedHealthcare of Arizona, Inc.; UnitedHealthcare of Arkansas, Inc.; UnitedHealthcare of Colorado, Inc.; UnitedHealthcare of Florida, Inc.; UnitedHealthcare of Georgia, Inc.; UnitedHealthcare of Illinois, Inc.; UnitedHealthcare of Kentucky, Ltd.; UnitedHealthcare of Louisiana, Inc.; UnitedHealthcare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; United HealthCare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New Mexico, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of North Carolina, Inc.; UnitedHealthcare of Ohio, Inc.; UnitedHealthcare of Oklahoma, Inc.; UnitedHealthcare of Oregon, Inc.; UnitedHealthcare of Pennsylvania, Inc.; UnitedHealthcare of Texas, Inc.; UnitedHealthcare of the Mid-Atlantic, Inc.; UnitedHealthcare of the Midlands, Inc.; UnitedHealthcare of the Midwest, Inc.; UnitedHealthcare of the Rockies, Inc.; UnitedHealthcare of Utah, Inc.; UnitedHealthcare of Washington, Inc.; UnitedHealthcare of Wisconsin, Inc.; UnitedHealthcare Plan of the River Valley, Inc. This list of health plans is complete as of the effective date of this notice. For a current list of health plans subject to this notice go to www.uhc.com/privacy/entities-fn-v1.

FINANCIAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW FINANCIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED.

PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2022

We³ are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information, other than health information, about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

Information We Collect

Depending upon the product or service you have with us, we may collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age, medical information and *Social Security* number.
- Information about your transactions with us, our affiliates or others, such as premium payment and claims history.
- Information from a consumer reporting agency.

Disclosure of Information

We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law. For example, in the course of our general business practices, we may, as permitted by law, disclose any of the personal financial information that we collect about you without your authorization, to the following types of institutions:

- To our corporate affiliates, which include financial service providers, such as other insurers, and non-financial companies, such as data processors.
- To nonaffiliated companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations.
- To nonaffiliated companies that perform services for us, including sending promotional communications on our behalf.

Confidentiality and Security

We maintain physical, electronic and procedural safeguards in accordance with applicable state and federal standards to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

Questions about this Notice

If you have any questions about this notice, please call the toll-free member phone number on your health plan ID card or call us at 1-866-633-2446 or TTY 711.

³For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities listed in footnote 2, beginning on the first page of the Health Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliates: AmeriChoice Health Services, Inc.; Dental Benefit Providers, Inc.; Ear Professional International Corporation; getthealthinsurance.com Agency, Inc.; Genoa Healthcare, LLC;

Golden Outlook, Inc.; Level2 Health IPA, LLC; Level2 Health Management, LLC; LifePrint Health, Inc.; Managed Physical Network, Inc.; Optum Care Networks, Inc.; Optum Global Solutions (India) Private Limited; OptumHealth Care Solutions, LLC; OptumHealth Holdings, LLC; Optum Labs, LLC; Optum Networks of New Jersey, Inc.; Optum Women's and Children's Health LLC, LLC; OrthoNet, LLC; OrthoNet West, LLC; OrthoNet of the South, Inc.; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; POMCO Network, Inc.; POMCO, Inc.; Real Appeal, Inc.; Sanvello Health, Inc.; Spectera, Inc.; Three Rivers Holdings, Inc.; UHC Holdings, Inc.; UMR, Inc.; United Behavioral Health; United Behavioral Health of New York I.P.A., Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Service LLC; Urgent Care MSO, LLC; USHEALTH Administrators, LLC; USHEALTH Group, Inc.; and Vivify Health, Inc. This Financial Information Privacy Notice only applies where required by law. Specifically, it does not apply to (1) health care insurance products offered in Nevada by Health Plan of Nevada, Inc. and Sierra Health and Life Insurance Company, Inc.; or (2) other UnitedHealth Group health plans in states that provide exceptions for HIPAA covered entities or health insurance products. This list of health plans is complete as of the effective date of this notice. For a current list of health plans subject to this notice go to www.uhc.com/privacy/entities-fn-v1.

Statement of Employee Retirement Income Security Act of 1974 (ERISA) Rights

As a participant in the plan, you are entitled to certain rights and protections under the *Employee Retirement Income Security Act of 1974 (ERISA)*.

Receive Information about Your Plan and Benefits

You are entitled to examine, without charge, at the Plan Administrator's office 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), if applicable, filed by the plan with the *U.S. Department of Labor* and available at the *Public Disclosure Room* of the *Employee Benefits Security Administration*.

You are entitled to get, 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), if applicable and updated *Summary Plan Description*. The Plan Administrator may make a reasonable charge for the copies.

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 due to a qualifying event. You or your Dependents may have to pay for such coverage. The Plan Sponsor is responsible for providing you notice of your *Consolidated Omnibus Budget Reconciliation Act (COBRA)* continuation rights. Review the *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 plan participants, *ERISA* imposes duties upon the people who are responsible for the operation of the employee benefit 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*.

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 get 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 \$156 a day (subject to adjustment based on inflation) until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan 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 is 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 get certain publications about your rights and responsibilities under *ERISA* by calling the publication hotline of the *Employee Benefits Security Administration*.

ERISA Statement

If the Group is subject to *ERISA*, the following information applies to you.

Summary Plan Description

Name of Plan: AIMS Benefit Trust Welfare Benefit Plan

Name, Address and Telephone Number of Plan Sponsor and Named Fiduciary:

AIMS Benefit Trust
890 Airport Park Road # 103
Glen Burnie, MD 21061
(410) 590-6590

The Plan Sponsor retains all fiduciary responsibilities with respect to the Plan, except to the extent the Plan Sponsor has assigned or allocated to other persons or entities one or more fiduciary responsibilities with respect to the Plan.

Claims Fiduciary: UnitedHealthcare Insurance Company ("UnitedHealthcare," refer to your Certificate of Coverage for details on the legal entity that provides your coverage) is your Plan's Claims Fiduciary and has been assigned this responsibility by your Plan Sponsor. Your Claims Fiduciary has the authority to require eligible individuals to furnish it with information necessary for the proper administration of your Plan.

Employer Identification Number (EIN): 52-1642161

Plan Number: 501

Plan Year: January 1 through December 31

Type of Plan: Health care coverage plan

Name, Business Address, and Business Telephone Number of Plan Administrator:

AIMS Benefit Trust
890 Airport Park Road # 103
Glen Burnie, MD 21061
(410) 590-6590

Type of Administration of the Plan: Your Plan is fully insured. Benefits are provided under a group insurance contract entered into between your Plan Sponsor and UnitedHealthcare. Claims for benefits are sent to UnitedHealthcare. Your employer and UnitedHealthcare share responsibility for administering the plan.

UnitedHealthcare
185 Asylum Street
Hartford, CT 06103-0450
877-294-1429

Person designated as Agent for Service of Legal Process: Plan Administrator

Discretionary Authority of Plan Administrator and Other Plan Fiduciaries: The Plan Administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for benefits in accordance with the terms of the Plan. Any interpretation or determination made according to such discretionary authority shall be given deference and be legally binding on all parties and subject to review by a legal authority only to the extent the decision was arbitrary and capricious.

Source of Contributions and Funding under the Plan: There are no contributions to the Plan. Any required employee contributions are used to partially reimburse the Plan Sponsor for Premiums under the Plan. Benefits under the Plan are funded by the payment of Premium required by the group Policy.

Method of Calculating the Amount of Contribution: Employee-required contributions to the Plan Sponsor are the employee's share of costs as determined by Plan Sponsor. From time to time, the Plan Sponsor will determine the required employee contributions for reimbursement to the Plan Sponsor and distribute a schedule of such required contributions to employees.

Qualified Medical Child Support Orders: The Plan's procedures for handling qualified medical child support orders are available without charge upon request to the Plan Administrator.

Amendment or Termination of the Plan: Your employer, as the Plan Sponsor, has the right to amend or terminate this Plan at any time. Note that the insurance contract, which is how benefits under the Plan are provided, is not necessarily the same as the Plan. As a result, termination of the insurance contract does not necessarily terminate the Plan.

