Optimum Choice, Inc.

Certificate of Coverage, Riders, Amendments and Notices
for
Educators Benefit Services, Inc.

Group Number:  717578

Effective Date:  January 1, 2013
Riders, Amendments, and Notices begin immediately following the last page of the Certificate of Coverage.
Optimum Choice, Inc.

Certificate of Coverage

Optimum Choice, Inc.
4 Taft Court
Rockville, MD 20850
# Certificate of Coverage Table of Contents

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## Section 1: What's Covered--Benefits

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Certificate of Coverage

Optimum Choice, Inc.
A UnitedHealthcare Company

Certificate is Part of Policy
This Certificate of Coverage ("Certificate") is part of the Policy that is a legal document between Optimum Choice, Inc. and the Enrolling Group to provide Benefits to Covered Persons, subject to the terms, conditions, exclusions and limitations of the Policy. We issue the Policy based on the Enrolling Group's application and payment of the required Policy Charges.

In addition to this Certificate the Policy includes:

- The Enrolling Group's application.
- Any Amendments and Riders.

You can review the Policy at the office of the Enrolling Group during regular business hours.

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

No one can make any changes to the Policy unless those changes are in writing.

Other Information You Should Have
Only we have the right to change, interpret, modify, withdraw or add Benefits, or to terminate 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 specified in the Policy. Coverage under the Policy will begin at 12:01 a.m. and end at 12:00 midnight Eastern time. The Policy will remain in effect as long as the Policy Charges are paid when they are due, subject to termination of the Policy.

We are delivering the Policy in the State of Maryland. The Policy is governed by ERISA unless the Enrolling Group is not an employee welfare benefit plan as defined by ERISA. To the extent that state law applies, the laws of the State of Maryland are the laws that govern the Policy.
OPTIMUM CHOICE, INC.

James A. Young, President and CEO

To continue reading, go to right column on this page.  To continue reading, go to left column on next page.
Introduction to Your Certificate

We are pleased to provide you with this Certificate. This Certificate and the other Policy documents describe your Benefits, as well as your rights and responsibilities, under the Policy.

How to Use this Document

We encourage you to read your Certificate and any attached Riders and/or Amendments carefully.

We especially encourage you to review the Benefit limitations of this Certificate by reading (Section 1: What's Covered--Benefits) and (Section 2: What's Not Covered--Exclusions). You should also carefully read (Section 9: General Legal Provisions) to better understand how this Certificate and your Benefits work. You should call us if you have questions about the limits of the Benefits available to you.

Many of the sections of the Certificate are related to other sections of the document. You may not have all of the information you need by reading just one section. We also encourage you to keep your Certificate and any attachments in a safe place for your future reference.

Please be aware that your Physician does not have a copy of your Certificate, and is not responsible for knowing or communicating your Benefits.

Information about Defined Terms

Because this Certificate 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 (Section 10: Glossary of Defined Terms). You can refer to Section 10 as you read this document to have a clearer understanding of your Certificate.

When we use the words "we," "us," and "our" in this document, we are referring to Optimum Choice, Inc. When we use the words "you" and "your" we are referring to people who are Covered Persons as the term is defined in (Section 10: Glossary of Defined Terms).

Your Contribution to the Required Premiums

The Policy may require the Subscriber to contribute to the required Premiums. You can contact your Enrolling Group for information about any part of the Premium cost you are responsible for paying.

Don't Hesitate to Contact Us

Throughout the document you will find statements that encourage you to contact us for further information. Whenever you have a question or concern regarding your Benefits, please call us using the telephone number for Customer Service listed on your ID card. It will be our pleasure to assist you.

To continue reading, go to right column on this page. To continue reading, go to left column on next page.
Section 1: What's Covered--Benefits

This section provides you with information about:
- Accessing Benefits.
- Copayments and Eligible Expenses.
- Out-of-Pocket Maximum.
- Covered Health Services. We pay Benefits for the Covered Health Services described in this section unless they are listed as not covered in (Section 2: What's Not Covered--Exclusions).
- Covered Health Services that require you or your provider to notify us before you receive them. In general, Network providers are responsible for notifying us before they provide certain health services to you.

Benefits are available only if all of the following are true:
- The health care service or supply is determined to be Medically Necessary.
- Covered Health Services are received while the Policy is in effect.
- Covered Health Services are received prior to the date that any of the individual termination conditions listed in (Section 8: When Coverage Ends) occurs.
- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements specified in the Policy.

When You Need a Doctor
You must show your identification card (ID card) or give insurance information every time you request health care services from a Network provider. If you do not show your ID card or give correct insurance information, Network providers have no way of knowing that you are enrolled under an Optimum Choice, Inc. Policy and we may deny your insurance claim and you will be liable for the payment. Your identification card eliminates the need for you to fill out claim forms. If you are unable to keep an appointment, call your doctor's office immediately so that your appointment can be used by someone else and a new appointment can be scheduled for you. Should your doctor have a policy of charging patients for broken

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appointments, you will be responsible for this charge, as it is not a Covered Health Service.

**Copayment**

Copayment is the amount you pay each time you receive certain Covered Health Services. For a complete definition of Copayment, see (Section 10: Glossary of Defined Terms). Copayment amounts are listed on the following pages next to the description for each Covered Health Service. Please note that when Copayments are calculated as a percentage (rather than as a set dollar amount) the percentage is based on Eligible Expenses.

**Eligible Expenses**

Eligible Expenses for Covered Health Services incurred while the Policy is in effect, are determined by us. For a complete definition of Eligible Expenses that describes how we determine payment, see (Section 10: Glossary of Defined Terms). You are not responsible for any difference between the Eligible Expenses and the amount the provider bills.
### Payment Information

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<td>Out-of-Pocket</td>
<td>The maximum you pay, out of your pocket, in a calendar year for</td>
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<td>Maximum</td>
<td>Copayments. For a complete definition of Out-of-Pocket Maximum, see</td>
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<td>% Copayments are based on a percent of Eligible Expenses</td>
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1. Acupuncture Services
Benefits for acupuncture services are provided only for postoperative and chemotherapy nausea and vomiting, nausea of Pregnancy, postoperative dental pain, and as part of a comprehensive treatment program for chronic pain when another method of pain management has failed.

Benefits are limited to 12 visits per calendar year.

2. Ambulance Services
Benefits are provided for Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be performed.

Benefits are also provided for Medically Necessary non-Emergency ambulance transportation which is authorized in advance by us.

3. Chiropractic Services
Benefits for Chiropractic Services provided by a Network

<table>
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<td>Emergency Ground Transportation:</td>
<td>No Copayment</td>
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<td>Description of Covered Health Service</td>
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<td>chiropractor.</td>
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Benefits for Chiropractic Services are limited to 20 visits per calendar year.

4. Chlamydia Screening Test
An annual chlamydia screening test for:

- Women who are either:
  - Younger than 20 years old who are sexually active.
  - At least 20 years old and have Multiple Risk Factors.
- Men who have Multiple Risk Factors.

The Copayment will be the same and will apply to the Out-of-Pocket Maximum in the same manner, as those stated under Physician's Office Services.

5. Treatment of Cleft Lip or Cleft Palate or Both
Benefits for orthodontics, oral surgery, and otologic, audiological, and speech/language treatment for an Enrolled Dependent child in connection with cleft lip or cleft palate, or both. Services must be provided by or under the direction of a Physician.

Depending upon where the Covered Health Service is provided, the Copayment will be the same and will apply to the Out-of-Pocket Maximum in the same manner, as those stated under Physician's Office Services, Dental Services - Adjunctive, Professional Fees for Surgical and Medical Services, Hospital-Inpatient Stay, Rehabilitation Services, and Outpatient Surgery, Diagnostic and Therapeutic Services.

6. Clinical Trials and Treatment Studies
Benefits for patient costs incurred during participation in clinical trials for prevention, early detection and treatment studies on cancer

Depending upon where the Covered Health Service is provided, the Copayment will be the same and will...
or treatment of other life-threatening conditions when ordered, provided or arranged by a Physician and authorized in advance by us.

In the case of cancer, the treatment must be conducted in a Phase I, Phase II, Phase III or Phase IV clinical trial. In the case of other life-threatening conditions, the treatment must be conducted in a Phase I, Phase II, Phase III or Phase IV clinical trial.

The clinical trial must be approved by one of the following: one of the National Institutes of Health (NIH); an NIH cooperative group or an NIH center; the Food and Drug Administration (FDA) in the form of an investigational new drug application; the Federal Department of Veterans Affairs; or an institutional review board of an institution in the State of Maryland that has a multiple project assurance contract approved by the Office of Protection from Research Risks of the NIH.

Benefits are provided only if all of the following apply:

- There is no clearly superior, non-investigational treatment alternative.
- The available clinical or preclinical data provides a reasonable expectation that the treatment will be at least as effective as the noninvestigational alternative.
- The treatment is within the scope of the practice, experience and training of the facility and personnel providing the treatment.

Benefits are provided only for the cost of health services that is incurred as a result of the treatment being provided to the Covered

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**Description of Covered Health Service**

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<th>Your Copayment Amount</th>
<th>Does Copayment Help Meet Out-of-Pocket Maximum?</th>
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<td>apply to the Out-of-Pocket Maximum in the same manner, as those stated under Physician's Office Services, Professional Fees for Surgical and Medical Services, Hospital-Inpatient Stay, and Outpatient Surgery, Diagnostic and Therapeutic Services.</td>
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Person for purposes of a clinical trial. Benefits are not provided for the cost of non-health care services that a patient may be required to receive as a result of the treatment being provided for purposes of a clinical trial, costs associated with managing the research associated with the clinical trial, or the cost of any investigational drug or device.

NOTE: Per Maryland state law, any Service Area and/or Network restrictions stated in this Certificate do not apply to Clinical Trials.

7. Dental Services - Accident only

Dental services when all of the following are true:

- Treatment is necessary because of accidental damage.
- Dental services are received from a Doctor of Dental Surgery, "D.D.S." or Doctor of Medical Dentistry, "D.M.D."
- The dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident.

Benefits are available only for treatment of a sound, natural tooth. The Physician or dentist must certify that the injured tooth was:

- A virgin or unrestored tooth, or
- A tooth that has no active decay, has at least 50% bony support, has no filling on more than two surfaces, has no root canal treatment, is not an implant, is not in need of treatment except as a result of the accident and functions normally in chewing and
speech. (Crowns, bridges and dentures are not considered sound, natural teeth.)

Dental services to repair damage caused by accidental injury must conform to the following time-frames:

- Treatment is started within three months of the accident, 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.

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

- Emergency examination.
- Necessary 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 is the only clinically acceptable treatment.
- Replacement of lost teeth due to the Injury.

When alternate methods may be used, we will authorize the least
### 8. Dental Services - Adjunctive

**Medically Necessary and Integral Dental Care**  
Benefits for dental care that is Medically Necessary and an integral part of the treatment of a Sickness or condition for which Covered Health Services are provided.

Examples of adjunctive dental care are:

- Extraction of teeth prior to radiation for oral cancer.
- Elimination of oral infection prior to transplant surgery.

Depending upon where the Covered Health Service is provided, the Copayment will be the same, and will apply to the Out-of-Pocket Maximum in the same manner, as those stated under Hospital-Inpatient Stay, Outpatient Surgery, Diagnostic and Therapeutic Services, Physician’s Office Services, Professional Fees for Surgical and Medical Services, and Prosthetic Devices.
- Removal of teeth in order to remove an extensive tumor.

Benefits are not available for treatment of dental disease that results from a medical condition. Examples of such excluded treatments include, but are not limited to, caries as a result of "dry mouth" caused by disease or medication and restoration of teeth damaged by acid reflux.

When alternate methods may be used, we will authorize the least costly Covered Health Service, provided that the services and supplies are considered by the profession to be an appropriate method of treatment, and meet broadly accepted national standards of dental practice. You and the provider may choose a more expensive level of care, but Benefits will be payable according to these guidelines.

**Non-Dental Oral Surgery**

Benefits are provided for non-dental oral surgery for the correction of deformities of the jaws due to congenital defects, Sickness or Injury. Examples of congenital syndromes are Pierre Robin Syndrome, Treacher-Collins Syndrome, and Crouzon's Syndrome. Benefits are not provided for pre or post-surgical orthodontics.

Benefits are not provided for procedures to correct open bites, cross bites, retruded or protruded jaws which are not related to congenital syndromes, Sickness or Injury unless a medically debilitating functional deficit is present, as determined at our sole discretion.

**Outpatient Facilities**
Benefits may be provided for outpatient facilities when there exists an underlying medical condition, co-morbidity, or significant risk factor which, as we determine, requires such a facility to control, monitor or treat the medical condition during or immediately after the procedure. Examples include: hemophilia, severe asthma, unstable heart disease, and unstable diabetes. In such cases, Benefits are provided for general anesthesia and associated facility charges, however Benefits are not provided for the dental procedures themselves unless the dental procedure is specifically stated as a Covered Health Service in this Certificate.

NOTE: These outpatient dental services are separate from and in addition to those provided for below under Dental Services - Hospital and Alternate Facility Health Services Related to Dental Care in accordance with state law.

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

General anesthesia and associated facility charges for dental services performed in a Hospital or Alternate Facility when the dentist and the Physician determine that such services are necessary for the safe and effective treatment of a dental condition. Such treatment is limited to a Covered Person who meets all requirements in one of the two following sets of conditions:

- Is 7 years of age or younger or is developmentally disabled.

Depending upon where the Covered Health Service is provided, the Copayment will be the same, and will apply to the Out-of-Pocket Maximum in the same manner, as those stated under Professional Fees for Surgical and Medical Services, Hospital-Inpatient Stay, and Outpatient Surgery, Diagnostic and Therapeutic Services.
- Is an individual for whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual, or other medically compromising condition of the enrollee or insured.

- Is an individual for whom a superior result can be expected from dental care provided under general anesthesia. 

Or

- 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.

- 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 Covered Health Services must be provided under the direction of a Physician or dentist. Benefits are not provided for the diagnosis or treatment of dental disease.

**10. Diabetes Treatment**

Benefits for diabetic equipment, diabetes supplies and in-person outpatient diabetic self-management training and education programs (including medical nutrition therapy) when provided under the direction of a Physician by a certified, registered or licensed health care professional.

The Copayment will be the same, and will apply to the Out-of-Pocket Maximum in the same manner, as stated under *Durable Medical Equipment, Hospital Inpatient Stay*, and *Physician's Office Services*. When diabetes equipment and supplies are obtained from a pharmacy, Benefits will be paid as described in the
### Description of Covered Health Service

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<tr>
<th>Description of Covered Health Service</th>
<th>Your Copayment Amount</th>
<th>Does Copayment Help Meet Out-of-Pocket Maximum?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes self-management training includes training provided to a Covered Person after the initial diagnosis of diabetes or pregnancy induced elevated blood glucose levels in the care and management of that condition, including nutritional counseling and proper use of diabetes equipment and supplies. 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.</td>
<td>% Copayments are based on a percent of Eligible Expenses</td>
<td>outpatient Prescription Drug Rider.</td>
</tr>
</tbody>
</table>

### 11. Durable Medical Equipment

Benefits for Durable Medical Equipment must meet each of the following criteria:

- Ordered or prescribed by a Physician as essential in the treatment of the Sickness, Injury or their symptoms.
- Able to withstand repeated use.
- Not useful generally to an individual in the absence of a Sickness, Injury or their symptoms.
- Primarily designated for medical purposes (not personal comfort or convenience).
- Primarily for use in the home.

If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the equipment that meets the minimum specifications for your needs.

Specific documentation of medical necessity by the ordering
Description of Covered Health Service

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Physician is required for all Durable Medical Equipment. We may require Physician notes and test reports to provide essential clinical information needed in the decision making process. Equipment may be authorized on a trial basis to determine effectiveness of treatment, and your compliance with the treatment plan. If a trial period is authorized, post trial documentation of continued need will be required for re-authorization.</td>
<td>% Copayments are based on a percent of Eligible Expenses</td>
<td></td>
</tr>
</tbody>
</table>

Examples of Durable Medical Equipment include:

- Equipment to assist 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).
- Delivery pumps for tube feedings (including tubing and connectors).
- Therapeutic shoes for diabetics.
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that are used for the purpose of supporting a weak or deformed body part (including braces to treat curvature of the spine) and braces restricting or eliminating motion in a diseased or injured part of the body are considered Durable Medical Equipment and are Covered Health Services. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or
acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).

We provide Benefits only for a single purchase (including repair/replacement) of a type of Durable Medical Equipment once every three calendar years or as needed to accommodate growth in children. Benefits for repair or replacement are not available for Durable Medical Equipment that has been lost, stolen, misused, maliciously damaged or grossly neglected.

We will decide if the equipment should be purchased or rented. You must purchase or rent the Durable Medical Equipment from a Network provider.

Durable Medical Equipment must be suitable for use in your home environment and not requested for use primarily outside the home. An institution may be considered a home. A Hospital, Skilled Nursing Facility, workplace or a school is not considered a home.

Benefits for Durable Medical Equipment are limited to $7,500 per calendar year. This limit applies to the total amount that we will pay for the Durable Medical Equipment (not including the equipment and supplies described under Diabetes Treatment above), and does not include any Copayment responsibility you may have.

12. Emergency Health Services
Services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an

<table>
<thead>
<tr>
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<tbody>
<tr>
<td></td>
<td>% Copayments are based on a percent of Eligible Expenses</td>
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</tbody>
</table>

$100 per visit No
### 13. Enteral Formulas

Benefits for enteral formulas including medical foods for malabsorption originating from congenital defects present at birth or acquired during the neonatal period, and Low Protein Modified Food Products for the treatment of Inherited Metabolic Diseases when prescribed and administered by a Physician qualified to provide diagnosis and treatment in the field of metabolic diseases.

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<tbody>
<tr>
<td></td>
<td>% Copayments are based on a percent of Eligible Expenses</td>
<td>No Copayment</td>
</tr>
</tbody>
</table>

No Copayment

### 14. Habilitative Services

Benefits for Habilitative Services for children under the age of nineteen (19) (but not including Habilitative Services provided through early intervention and school services). See (Section 10: Glossary of Defined Terms) for a definition of Habilitative Services.

Depending upon where the Covered Health Service is provided, the Copayment will be the same, and will apply to the Out-of-Pocket Maximum in the same manner, as those stated under **Physician's Office Services, Professional Fees for Surgical and Medical Services, Hospital-Inpatient Stay, Rehabilitation Services, and Outpatient Surgery, Diagnostic and Therapeutic Services**.

### 15. Hearing Aids for Minor Children

Benefits for the cost of non-disposable hearing aids for minor children when prescribed, fitted and dispensed by a licensed audiologist.

Benefits for Hearing Aids are limited to $1,400 per ear every 36 months at a Hospital.

You will find more information about Benefits for Emergency Health Services in (Section 3: Obtaining Benefits).
16. **Home Health Care**

Services and supplies received from a Home Health Agency that are both of the following:

- Ordered by a Physician.
- Provided by or supervised by a registered nurse in your home.

Benefits are available only when the Home Health Agency services are provided on a part-time, intermittent schedule and when skilled care is required.

Skilled care is skilled nursing and skilled teaching when all of the following are true:

- It 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.
- It is ordered by a Physician.
- It is 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.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

We will decide if skilled care is required by reviewing both skilled
### Covered Health Service

<table>
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<tr>
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<tr>
<td></td>
<td>% Copayments are based on a percent of Eligible Expenses</td>
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</table>

nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

In accordance with state law, Home Health Care services are available for the following:

- One home visit and an additional home visit when prescribed by a Physician for a mother and newborn child following discharge from a Hospital prior to the 48 or 96 hour limits described below under Maternity Services. Such newborn home visits are not subject to the payment of Copayments, deductibles or coinsurance.

- One home visit when prescribed by a Physician for a mother and newborn child following discharge from a Hospital after the 48 or 96 hour limits described below under Maternity Services. Such a home visit is not subject to the payment of Copayments, deductibles or coinsurance.

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 a registered nurse with at least 1 year of experience in maternal and child health nursing or community health nursing with an emphasis on maternal and child health.

- They will include any services required by the attending
health care provider.

- One home visit and an additional home visit when prescribed by a Physician following a mastectomy if the patient is either hospitalized for less than 48 hours following the surgery or undergoes a mastectomy on an outpatient basis.

- One home visit and an additional home visit when prescribed by a Physician following surgery for removal of a testicle if the patient is either hospitalized for less than 48 hours following the surgery or undergoes the surgical removal of a testicle on an outpatient basis.

  The initial visit should be scheduled to occur within 24 hours of discharge.

Benefits are limited to 200 visits per calendar year. One visit equals up to four hours of skilled care services.

The home visits described above in connection with newborns, mastectomy, and removal of a testicle do not apply to this visit limit.

17. Hospice Care

Benefits received through a Hospice Care Program that is recommended by a Physician. See (Section 10: Glossary of Defined Terms) for a definition of Hospice Care Program and other terms used to describe this Benefit.

Hospice Care Program Benefits include the following:

- days of inpatient care per Covered Person.
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<tbody>
<tr>
<td>Part-time nursing care by or supervised by a registered graduate nurse.</td>
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<tr>
<td>Counseling, including dietary counseling, for the Terminally Ill person.</td>
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<tr>
<td>Family Counseling for the Immediate Family and the Family Caregiver before the death of the Terminally Ill insured.</td>
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<tr>
<td>Bereavement Counseling for the Immediate Family or Family Caregiver of the insured for at least the 6-month period following the insured's death or 15 visits, whichever occurs first.</td>
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<tr>
<td>Respite Care subject to both of the following:</td>
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<td>— The annual benefit shall be at least 14 days.</td>
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<tr>
<td>— We may limit any one inpatient stay for Respite Care to 5 consecutive days.</td>
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<tr>
<td>Medical supplies, equipment, and medication required to maintain the comfort and manage the pain of the Terminally Ill person.</td>
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</table>

Please contact us for more information regarding our guidelines for hospice care. You can contact us at the telephone number on your ID card.

Benefits are limited to 360 days during the entire period of time you are covered under the Policy.

### 18. Hospital - Inpatient Stay

Inpatient Stay in a Hospital. Benefits are available for:

- $300 per
- No
### 19. Infertility Services

For the purposes of describing Benefits available under this section, infertility is defined as the inability to achieve Pregnancy after one year of unprotected intercourse. Benefits for services to achieve Pregnancy after adequate work-up for habitual miscarriage will be available after the above criterion is met. Women without male partners may meet the above definition by substituting 12 consecutive monthly medically supervised and documented artificial inseminations (at their own expense) in place of intercourse.

Benefits are provided for the following infertility services:

- Testing.
- Medical advice.
- Surgical correction of the structural cause of infertility.
- Artificial insemination, limited to a maximum of 6 cycles per Covered Person during the entire period of time you are enrolled under the Policy.
20. 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 all the following apply:

- The patient's oocytes are fertilized with the sperm of the patient's spouse.
- The patient and the patient's spouse have a history of infertility of at least 2 years duration or a 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.
  — Abnormal male factors, including oligospermia, contributing to the infertility.
- The patient has been unable to conceive through less costly infertility treatments covered under the Policy.
- The in vitro fertilization procedures are performed at medical facilities that conform to the American College of Obstetricians and Gynecologists guidelines for in vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in vitro fertilization.

In vitro Benefits are limited to three in vitro fertilization attempts depending upon where the Covered Health Service is provided, the Copayment will be the same, and will apply to the Out-of-Pocket Maximum in the same manner, as those stated under Physician's Office Services, Professional Fees for Surgical and Medical Services, and Outpatient Surgery, Diagnostic and Therapeutic Services.
Description of Covered Health Service

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</table>

per live birth, subject to a lifetime maximum Benefit of $100,000.

21. Maternity Services

Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications including a hearing loss screening for the newborn child prior to discharge from the Hospital.

We will reimburse up to $50 for childbirth education classes. Upon completion of the class, you must submit a copy of the certificate of completion with dates attended, as well as a copy of the canceled check or receipt.

We also have special prenatal programs to help during Pregnancy. They are completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify us during the first trimester, but no later than one month prior to the anticipated childbirth.

Depending upon where the Covered Health Service is provided, the Copayment will be the same, and will apply to the Out-of-Pocket Maximum in the same manner, as those stated under Hospital-Inpatient Stay, Outpatient Surgery, Diagnostic and Therapeutic Services, Physician's Office Services, and Professional Fees for Surgical and Medical Services.

No Copayment applies to Physician office visits for prenatal care after the first visit.
We will pay Benefits for an Inpatient Stay of at least:

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

A mother may request a shorter length of stay than that provided above if the mother decides, in consultation with the mother’s attending health care provider, that less time is needed for recovery. In the event of such a shorter stay, Benefits will be provided for at least one home care visit as described above under Home Health Care. If the mother and newborn child remain in the Hospital for at least as long as the minimum inpatient confinement periods shown above, a single home visit will be provided if prescribed by the attending health care provider. These Home Health Care visits are described above under Home Health Care.

Whenever a mother is required to remain hospitalized after childbirth for medical reasons and the mother requests that the newborn remain in the hospital, we will pay Benefits for the cost of additional hospitalization for the newborn for up to 4 days.

### 22. Mental Health and Substance Abuse Services

Benefits for the diagnosis and treatment of mental illnesses, emotional disorders, alcohol and substance abuse/dependence are provided when the following are true:

<table>
<thead>
<tr>
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</table>

For outpatient services:

- 20% of Eligible
- Yes
The mental illness, emotional disorder, alcohol and substance abuse/dependence is diagnosed according to criteria included in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

We determine that the mental illness, emotional disorder, alcohol and substance abuse/dependence is treatable and the services provided are Medically Necessary.

An office visit to a Physician or other health care provider for medication management:

- Will not be counted against the number of visits shown in the Your Copayment Amount column.
- Will be reimbursed under the same terms and conditions as an office visit for a physical illness as shown below under Physician's Office Services.

Benefits are provided only when the mental health services and/or substance abuse services are authorized in advance by your Primary Care Physician as Medically Necessary and treatable at an appropriate level of care. If your Primary Care Physician refers you for treatment, that treatment must be coordinated through a Network behavioral health practitioner.

Once you have been referred for mental health services and/or substance abuse services, you will be evaluated by a Network behavioral health practitioner, who will initially discuss a recommended course of treatment at the appropriate provider level.

For inpatient services:

- $300 per Inpatient Stay
- No

### Description of Covered Health Service

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<th>Does Copayment Help Meet Out-of-Pocket Maximum?</th>
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</thead>
<tbody>
<tr>
<td>Visit to a Physician or other health care provider for medication management</td>
<td>% Copayments are based on a percent of Eligible Expenses</td>
<td>Expenses for visits 1 through 5 in a Policy year; 35% of Eligible Expenses for visits 6 through 30 in a Policy year; 50% of Eligible Expenses for visits 31 or more in a Policy year.</td>
</tr>
</tbody>
</table>

*Section 1: What's Covered--Benefits*
We provide Benefits for individual, group and family therapy when Medically Necessary, at an appropriate level of care. Benefits are provided for family therapy, including couples therapy, as part of ongoing therapy or treatment for the patient who is originally referred by the Primary Care Physician and each visit will be counted as one visit for the identified patient.

Benefits are available for Medically Necessary intervention, at an appropriate level of care, and subject to the Benefit limits stated below, including, but not limited to:

- Diagnostic evaluation including psychological and neuropsychological testing.
- Outpatient psychiatric and substance abuse treatment including individual, group and family therapy.
- Semi-private room and other inpatient services and supplies in a Hospital or a licensed and certified Treatment Facility including Residential Crisis Services and Physician services.
- An involuntary admission, when deemed Medically Necessary by the evaluating Network behavioral health practitioner, when the patient is regarded as dangerous to himself/herself or others in accordance with the jurisdiction's involuntary commitment or certification procedures.

60 days of Partial Hospitalization Benefits are provided each calendar year. For Partial Hospitalization, the Copayment will be the same, and will apply to the Out-of-Pocket Maximum in the same
23. Morbid Obesity Treatment
Benefits for the treatment of Morbid Obesity through a surgical method that is:

- Recognized by the National Institutes of Health as effective for the long-term reversal of Morbid Obesity; and
- Consistent with guidelines approved by the National Institutes of Health.

See (Section 10: Glossary of Defined Terms) for a definition of Morbid Obesity.

24. Ostomy and Urologic Supplies
Benefits for ostomy supplies and for urologic supplies required by Covered Persons with permanent incontinence including, but not limited to, pouches, barriers and catheters. Ostomy supplies and urologic supplies must be purchased from a Network provider.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive and adhesive removers.

Benefits for ostomy supplies and urologic supplies are limited to $7,500 per calendar year. This limit applies to the total amount that we will pay for the supplies, and does not include any Copayment.
25. Outpatient Surgery, Diagnostic and Therapeutic Services

Outpatient Surgery
Covered Health Services for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services, including the surgeon’s fees, are described under Professional Fees for Surgical and Medical Services.

When these services are performed in a Physician's office, Benefits are described under Physician's Office Services below.

Outpatient Diagnostic Services
Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including:

- Lab and radiology/X-ray.
- Mammography.
- Benefits for bone mass measurement (a radiologic or radioisotopic procedure, or other scientifically proven...
technology) for the prevention, diagnosis, and treatment of osteoporosis when the bone mass measurement is requested by a Physician. Benefits for bone mass measurement include, but are not limited to, those provided when:

— You are at risk for osteoporosis.
— You have 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, who is a candidate for therapeutic intervention or for an extensive diagnostic evaluation for metabolic bone disease.
— You are receiving long-term glucocorticoid (steroid) therapy.
— You have hyperparathyroidism.
— You are being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

Benefits under this section 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 Professional Fees for Surgical and Medical Services.

When these services are performed in a Physician's office, Benefits are described under Physician's Office Services below.

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</thead>
<tbody>
<tr>
<td>For preventive mammography:</td>
<td>No Copayment</td>
<td>No</td>
</tr>
<tr>
<td>For Sickness and Injury-related diagnostic</td>
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<tr>
<td>Description of Covered Health Service</td>
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<tr>
<td><strong>Outpatient Diagnostic/Therapeutic Services - CT Scans, PET Scans, MRI and Nuclear Medicine</strong></td>
<td>$0 at an Alternate Facility; $30 at a Hospital</td>
<td>No</td>
</tr>
<tr>
<td>Covered Health Services for CT scans, PET scans, MRI, and nuclear medicine received on an outpatient basis at a Hospital or Alternate Facility. Benefits under this section include:</td>
<td>$30 at an Alternate Facility; $30 at a Hospital</td>
<td>No</td>
</tr>
<tr>
<td>• The facility charge and the charge for related supplies and equipment.</td>
<td>$30 per Network dialysis center visit</td>
<td>No</td>
</tr>
<tr>
<td>• Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described under <em>Professional Fees for Surgical and Medical Services.</em></td>
<td>$30 at an Alternate Facility; $30 at a Hospital</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Therapeutic Treatments</strong></td>
<td>$30 per Network dialysis center visit</td>
<td>No</td>
</tr>
<tr>
<td>Covered Health Services for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including radiation therapy, dialysis, intravenous chemotherapy or other intravenous infusion therapy, and other treatments not listed above. Benefits under this section include:</td>
<td>$30 at an Alternate Facility; $30 at a Hospital</td>
<td></td>
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<tr>
<td>• The facility charge and the charge for related supplies and equipment.</td>
<td>$30 at a Hospital</td>
<td></td>
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<tr>
<td>• Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described under <em>Professional Fees for Surgical and Medical Services.</em></td>
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<tr>
<td>radiologists. Benefits for other Physician services are described under Professional Fees for Surgical and Medical Services. When these services are performed in a Physician's office, Benefits are described under Physician's Office Services below.</td>
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### 26. Physician's Office Services

**Covered Health Services for preventive medical care.**

Preventive medical care includes:

- Voluntary family planning. Benefits include insertion and removal of IUDs, Depo-Provera, implants for the purpose of contraception, and genetic counseling.
- Well-baby and well-child care.
- Routine physical examinations.
- Vision and hearing screenings. (Vision screenings do not include refractive examinations to detect vision impairment. See Vision Examinations later in this section.)
- Immunizations in accordance with our guidelines.
- Colorectal Cancer screenings in accordance with the latest screening guidelines issued by the American Cancer Society.
- A Human Papillomavirus Screening Test at the testing intervals recommended by the American College of Obstetricians and Gynecologists.

Covered Health Services for the diagnosis and treatment of a condition requiring medical care $20 per visit, except that the

No Copayment

No
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<tbody>
<tr>
<td>Sickness or Injury.</td>
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27. Professional Fees for Surgical and Medical Services
Professional fees for surgical procedures and other medical care received in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* above.

28. Prostate Cancer Screening
Benefits include, but are not limited to:

- A diagnostic examination for the detection of prostate cancer and a prostate-specific antigen test (PSA) for Covered Persons who are between 40 and 75 years of age.
- Benefits apply when used to:
  - Evaluate the response to prostate cancer treatment.
  - Determine the need for a bone scan in patients with prostate cancer.

Depending upon where the Covered Health Service is provided, the Copayment will be the same, and will apply to the Out-of-Pocket Maximum in the same manner, as those stated under *Physician's Office Services* and *Outpatient Diagnostic Services*. 
— Monitor patients who are at high risk for prostate cancer.

Coverage for the diagnostic examination shall be provided in accordance with guidelines established by the American Cancer Society.

### 29. Prosthetic Devices

Benefits for external prosthetic devices that replace a limb or an external body part are limited to the following when determined to be Medically Necessary:

- Artificial arms, legs, feet and hands.
- Artificial eyes, ears and noses.
- Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. Benefits include mastectomy bras and lymphedema stockings for the arm.
- A single hair prosthesis for loss of natural hair resulting from chemotherapy or radiation treatment for cancer.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the most cost-effective prosthetic device.

The prosthetic device must be ordered or provided by, or under the direction of a Physician. Except for items required by the Women's Health and Cancer Rights Act of 1998, Benefits for prosthetic devices are limited to a single purchase of each type of prosthetic device every three calendar years or as needed to accommodate...
growth in children. Socket replacements may be considered if the Covered Person has a documented significant change in residual volume or weight.

Benefits for prosthetic devices, other than hair and breast prostheses, are limited to $7,500 per calendar year. This limit applies to the total amount that we will pay, and does not include any Copayment responsibility you may have. Once this limit is reached, Benefits continue to be available for items required by the Women's Health and Cancer Rights Act of 1998.

Benefits for a hair prosthesis are limited to a lifetime maximum of $350.

30. Reconstructive Procedures
Services for reconstructive procedures, when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures that are associated with an Injury, Sickness or Congenital Anomaly. The fact that physical appearance may change or improve as a result of a reconstructive procedure does not classify such surgery as a Cosmetic Procedure when a physical impairment exists, and the surgery restores or improves function.

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 a Covered Person may suffer psychological

Depending upon where the Covered Health Service is provided, the Copayment will be the same, and will apply to the Out-of-Pocket Maximum in the same manner, as those stated under Hospital-Inpatient Stay, Outpatient Surgery, Diagnostic and Therapeutic Services, Physician's Office Services, Professional Fees for Surgical and Medical Services, and Prosthetic Devices.
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<td>% Copayments are based on a percent of Eligible Expenses</td>
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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 breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. You can contact us at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

### 31. Rehabilitation Services

Short-term rehabilitation services for:

- Physical therapy including biofeedback.
- Occupational therapy.
- Speech therapy.
- Outpatient pulmonary rehabilitation therapy.
- Outpatient cardiac rehabilitation therapy.

Rehabilitation services must be performed by a licensed therapy provider, under the direction of a Physician.

Benefits are available only for short-term rehabilitation services to treat conditions that are subject to measurable improvement as determined by us, using nationally recognized guidelines, provided that you continue to make progress. Short-term therapy will be terminated when further progress toward the established goal is

Depending upon where the Covered Health Service is provided, the Copayment will be the same, and will apply to the Out-of-Pocket Maximum in the same manner, as those stated under Hospital-Inpatient Stay, Outpatient Surgery, Diagnostic and Therapeutic Services, Physician’s Office Services, Professional Fees for Surgical and Medical Services, and Prosthetic Devices.
unlikely or therapy treatments can be maintained or provided by the Covered Person, family, or care aid, etc.

Please note that we will pay Benefits for short-term speech therapy only when necessary to correct an impairment of organic origin due to accident or Sickness, or following surgery to correct a Congenital Anomaly.

Benefits are limited as follows:

Any combination of physical therapy, occupational therapy or speech therapy services provided on an outpatient basis, at an Inpatient Rehabilitation Facility, or in a day treatment or home setting is limited to 100 visits or 100 days, whichever is greater, per Sickness or Injury. Limits do not apply to biofeedback.

Rehabilitation services received in connection with Treatment of Cleft Lip or Cleft Palate or Both and Habilitative Services as described above are not subject to these Benefit limitations.

In addition, Benefits are provided for pulmonary rehabilitation therapy and cardiac rehabilitation therapy, and limited as follows:

- 20 outpatient visits of pulmonary rehabilitation therapy per calendar year.
- 36 outpatient visits of cardiac rehabilitation therapy per calendar year.

### 32. Skilled Nursing Facility Services

Services for an Inpatient Stay in a Skilled Nursing Facility. Benefits

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<th>Description of Covered Health Service</th>
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No Copayment

No
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 anesthesiologists, Emergency room Physicians, pathologists and radiologists. Benefits for other Physician services are described under Professional Fees for Surgical and Medical Services.

Benefits are limited to 180 days per calendar year.

Please note that Benefits are available only for the care and treatment of an Injury or Sickness that would have otherwise required an Inpatient Stay in a Hospital.

### 33. Temporomandibular Disorder (TMD) Services

Benefits for Covered Health Services provided by a Physician in an office setting, when the service is Medically Necessary and proven to be effective for treatment of temporomandibular disorder (TMD) and/or related myofascial pain dysfunction.

Benefits for Medically Necessary surgical services that are proven to be effective are provided if all of the following criteria are met:

- There is clearly demonstrable radiographic evidence of joint

Depending upon where the Covered Health Service is provided, the Copayment will be the same, and will apply to the Out-of-Pocket Maximum in the same manner, as those stated under Physician's Office Services, Professional Fees for Surgical and Medical Services, Hospital-Inpatient Stay and Outpatient Surgery, Diagnostic and Therapeutic Services.
abnormality.

- Conservative non-surgical treatment has failed to adequately resolve the symptoms.
- Pain or function is moderate to severe in nature and interferes with the performance of daily tasks and is refractory to non-surgical treatment.

### 34. Transplantation Services

Covered Health Services for the following organ and tissue transplants when ordered by a Network Physician. Transplantation services must be received at a Designated Facility. Benefits are available for the transplants listed below when the transplant meets the definition of a Covered Health Service, and is not an Experimental, Investigational or Unproven Service:

- Bone marrow transplants (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy.
- Heart transplants.
- Heart/lung transplants.
- Lung transplants.
- Kidney transplants.
- Kidney/pancreas transplants.
- Liver transplants.
- Liver/small bowel transplants.
- Pancreas transplants.
Small bowel transplants.

Benefits are also available for cornea transplants that are provided by a Network Physician at a Network Hospital. We do not require that cornea transplants be performed at a Designated Facility.

Benefits are provided for the cost of services related to the screening of organ donors for the actual organ donor only.

Organ or tissue transplants or multiple organ transplants other than those listed above are excluded from coverage.

We have specific guidelines regarding Benefits for transplant services. Contact us at the telephone number on your ID card for information about these guidelines.

35. Urgent Care Center Services
Covered Health 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 earlier in this section.

$50 per visit No

36. Vision Examinations
Routine vision examinations (including refraction) to detect vision impairment received from a Network Physician or other Network health care provider in an office setting.

Benefits are limited to one vision examination each calendar year.

$30 per visit No
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Please note that Benefits are not available for charges connected to the purchase or fitting of eyeglasses or contact lenses.
Section 2: What's Not Covered--Exclusions

This section contains information about:
• How headings are used in this section.
• Medical services that are not covered. We call these Exclusions. It's important for you to know what services and supplies are not covered under the Policy.

How We Use Headings in this Section
To help you find specific exclusions more easily, we use headings. The headings group services, treatments, items, or supplies that fall into a similar category. Actual exclusions appear underneath headings. A heading does not create, define, modify, 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 are 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 Services, except as may be specifically provided for in (Section 1: What's Covered--Benefits) or through a Rider to the Policy.

A. Alternative Treatments
1. Acupressure.
2. Aroma therapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.
6. Alternative medical equipment, devices and supplies such as magnets or massage devices, herbs and vitamins. Biofeedback equipment.
7. Other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.

B. Comfort or Convenience
1. Television.
2. Telephone.
3. Beauty and 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.
   — Batteries and battery chargers, including those used with Durable Medical Equipment.
   — Dehumidifiers.
— Humidifiers.
— Elevators.
— Stair lifts.
— Posture chairs.
— Floor sitters.
— Bathroom scales.
— Wheelchair desks.

6. Devices and computers to assist in communication and speech.
7. Equipment for which the primary function is vocationally or educationally related such as Braille training text.

C. Dental

1. Routine dental treatment, X-rays, preventive care, diagnosis, and treatment of or related to teeth, their supporting structures (including the jawbones) and gums, unless provided for in (Section 1: What's Covered--Benefits). Examples include the following:
   — Extraction, restoration and replacement of teeth.
   — Medical or surgical treatments of dental conditions except as described in (Section 1: What's Covered--Benefits) under the heading Dental Services - Hospital and Alternate Facility Services Related to Dental Care.
   — Services to improve dental clinical outcomes.
2. Dental implants and bone grafts related to implant placement.
3. Orthodontic correction of malocclusion.
4. Treatment for congenitally missing, malpositioned, or supernumerary teeth, even if part of a Congenital Anomaly.

5. Removal of maxillary and mandibular tori and exostoses unless Medically Necessary.
6. Frenectomy, unless Medically Necessary.

D. Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill.
2. Self-injectable medications.
3. Non-injectable medications given in a Physician's office except as required in an Emergency.
4. Over-the-counter drugs and treatments.

E. Experimental, Investigational or Unproven Services

Experimental, Investigational and Unproven Services are excluded. The fact that an Experimental, 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, Investigational or Unproven in the treatment of that particular condition.

F. Foot Care

1. Routine foot care (including the cutting or removal of corns and calluses).
2. Nail trimming, cutting, or debriding.
3. Hygienic and preventive maintenance foot care. Examples include the following:
   — Cleaning and soaking the feet.
   — Applying skin creams in order to maintain skin tone.
— Other services that are performed when there is not a localized illness, injury or symptom involving the foot.

4. Treatment of flat feet.

5. Treatment of subluxation of the foot.

6. Shoe orthotics and orthopedic shoes. This exclusion does not apply to therapeutic shoes for diabetics, for which Benefits are available as described in (Section 1: What’s Covered—Benefits).

G. Medical Supplies and Appliances

1. Devices used specifically as safety items or to affect performance in sports-related activities.

2. Prescribed or non-prescribed medical supplies and disposable supplies except as described in (Section 1: What’s Covered—Benefits) under the heading Diabetes Treatment. Examples include:
   — Elastic stockings and compression garments.
   — Ace bandages.
   — Gauze and dressings.
   — The following ostomy supplies: deodorants, filters, lubricants, tape, appliance cleaners, adhesive and adhesive removers.

3. Orthotic appliances that straighten or re-shape a body part (including cranial banding/helmets and some types of braces). Carpal tunnel splints.

4. Tubings and masks are not covered except when used with Durable Medical Equipment as described in (Section 1: What’s Covered—Benefits).

5. All over-the-counter medical equipment, devices or supplies defined as items which can be typically purchased at (including, but not limited to) a local pharmacy, supermarket, internet site, general publication or medical supply storefront and do not require a Physician’s prescription for purchase.

6. The following equipment, supplies and devices:
   — Mobility chairs or strollers if a manual or power wheelchair is the primary means of mobility and is owned or rented by the Covered Person.
   — Duplicate, backup or alternative equipment such as manual wheelchairs that back up power wheelchairs (the Covered Person's primary means of mobility) or a second nebulizer machine for portability.
   — Parts and labor costs for supplies and accessories replaced due to wear and tear, such as wheelchair tires, tubes, brakes or upholstery.
   — Scooters (power operated vehicles).
   — Car seats. Home and vehicle modifications.
   — Seat lifts, chairs and lift mechanisms.
   — Manual or electronic blood pressure cuffs.
   — Stethoscopes.
   — Breast pumps.
   — Cold therapy devices, icepacks, heating pads or thermal wraps.
   — Whirlpools, wax treatment/paraffin baths.
   — Cervical, thoracic, lumbar or sacral pillows, wedges, supports or cushions.
   — Physical fitness equipment, massage tables, inversion tables.
   — Ergonomic office equipment.
— Home therapeutic monitoring devices such as "Coagucheck".
— Aids for activities of daily living such as transfer benches, grab bars, reachers, utensil holders, button zipper pulls.
— Personal hygiene equipment, devices or supplies such as toileting systems or hygienic assistive devices such as bath tub lifts or seats or raised toilet seats.
— Standing tables, adaptive positioning and assistive technology devices.
— Incontinent pads and diapers. Drionic (anti-sweat) devices, bed wetting control devices.
— Equipment, devices and supplies designed to improve self image or self esteem.

H. Mental Health/Substance Abuse
Benefits for mental health and substance abuse services are excluded for the following:

1. Treatment for a condition determined by the Network behavioral health practitioner to be untreatable.
2. Services that are not Medically Necessary.
3. Services when a Covered Person has either not cooperated with the treatment plan recommended by his or her Network behavioral health provider or signed out of a facility against the medical advice of the Network behavioral health provider. (Upon appeal, all such cases will be reviewed and Benefits reinstated when medically indicated.)
4. Residential Treatment and services except as described in (Section 1: What's Covered--Benefits) under the heading Mental Health and Substance Abuse Services.
5. Psychiatric therapy on court order or as a condition of parole or probation.
6. Psychiatric or psychological evaluation primarily for legal or administrative purposes including, but not limited to, the determination of disability or for security clearances.
7. Court appearances by a mental health or substance abuse provider.
8. Testing for specific learning disabilities, intelligence, or for career aptitude and interests.
9. Acupuncture, biofeedback and hypnotherapy for mental health or substance abuse conditions.
10. Mental health services related to sex transformation, sterilization reversals or sexual dysfunction.
11. Special education, counseling, therapy or care for learning deficiencies or behavioral problems. This applies whether associated with manifest mental illness or other disturbances.
12. Confinement, treatment, services or supplies related to learning disabilities, mental retardation and/or mental deficiency.
13. Educational assessments and vocational training.
14. Inpatient or day treatment programs for pain management, unless deemed appropriate by us.
15. Treatment for organic mental disorder when the disorder is due to permanent brain dysfunction.
16. Treatment related to autism and treatment of pervasive development disorder except as described in (Section 1: What's Covered--Benefits) under the heading Habilitative Services. This exclusion does not apply to the assessment for initial diagnosis of these disorders.
17. Treatment for sexual addiction, gambling and codependency.
18. Sexual therapy.
20. Treatment focused primarily on marital, child support or custody proceedings.
21. Psychotherapy and any other consultations done by telephone.
22. Psychoanalysis.
23. Treatment directed towards a professional certification or whose primary purpose is personal growth and development.
24. During inpatient hospitalizations for mental health or substance abuse treatment, services beyond one individual and up to one group session per day.
25. Two or more levels of care that occur simultaneously including, but not limited to, inpatient treatment and partial day hospitalization or inpatient treatment and outpatient treatment.
26. Court ordered examinations and care.
27. Non-Medically Necessary ancillary services, such as halfway housing.

I. Nutrition
1. Megavitamin and nutrition based therapy.
2. Dietary supplements, replacements or vitamins.
3. Nutritional counseling for either individuals or groups except as described in (Section 1: What's Covered--Benefits) under the heading *Diabetes Treatment*.
4. Except as described in (Section 1: What's Covered--Benefits) under the heading *Enteral Formulas*, enteral feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk.

J. Physical Appearance
1. Cosmetic Procedures. See the definition in (Section 10: Glossary of 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.
2. Any services made necessary because of complications in connection with Cosmetic Procedures.
3. Rhinoplasty or septrhinoplasty unless approved within 6 months of a documented nasal fracture.
4. Sclerotherapy performed on the arms, legs, feet or hands.
5. 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 initial breast implant followed mastectomy. See *Reconstructive Procedures* in (Section 1: What's Covered--Benefits).
6. Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation.
7. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
8. Wigs regardless of the reason for the hair loss except as described in (Section 1: What's Covered--Benefits) under the heading *Prosthetic Devices*.

K. Providers
1. Services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent or...

*To continue reading, go to right column on this page.*
child. This includes any service the provider may perform on himself or herself.

2. Services performed by a provider with your same legal residence.

3. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services that are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:
   — Has not been actively involved in your medical care prior to ordering the service, or
   — Is not actively involved in your medical care after the service is received.

This exclusion does not apply to mammography testing.

L. Reproduction

1. All cost associated with a non-Covered Person's function as a surrogate parent and/or host uterus.

2. Reversal of voluntary sterilization.

3. All infertility services after voluntary sterilization or reversal of voluntary sterilization of either partner.

4. Gamete intra-fallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT); costs associated with the collection, storage and harvesting of ovum or ova, embryo transfers, costs associated with the retrieval of eggs. Services provided solely to prepare for these excluded services.

5. Costs associated with storage and cryopreservation of ova, embryo, or sperm. All costs associated with donor sperm and donor eggs.

6. Infertility services for a non-covered spouse or partner.

7. Sex selection, gene therapy, genetic alteration, genetic testing of embryos prior to implantation.

8. Services which we determine are unlikely to result in Pregnancy.

M. Services Provided under Another Plan

1. Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes, but is not limited to, coverage required by workers' compensation or similar legislation.

   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 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 services while on active military duty.

N. Transplants

1. Health services for organ and tissue transplants, except those described in (Section 1: What's Covered--Benefits).

2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's Benefits under the Policy.)

3. Health services for transplants involving mechanical or animal organs.
4. Transplant services that are not performed at a Designated Facility. Note: This Exclusion does not apply to cornea transplants.

5. Any multiple organ transplant not listed as a Covered Health Service under the heading *Transplantation Services* in (Section 1: What’s Covered--Benefits).

6. Any service associated with a non-covered transplant including, but not limited to, any service associated with complications of a non-covered transplant.

**O. Travel**

1. Health services provided in a foreign country, unless required as Emergency Health Services.

2. Travel or transportation expenses, even though prescribed by a Physician.

**P. Vision and Hearing**

1. Purchase cost of eyeglasses and contact lenses for medical conditions or vision correction, except for Aphakia or Keratoconus.

2. Hearing aids (including bone-anchored hearing aids) and any other external hearing enhancement device except as described in (Section 1: What’s Covered--Benefits) under the heading *Hearing Aids for Minor Children*.

3. Fitting charge for hearing aids, eyeglasses or contact lenses.

4. Eye exercise therapy/vision therapy and vision therapy devices.

5. Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery.

**Q. All Other Exclusions**

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in (Section 10: Glossary of Defined Terms).

2. Any health care service or supply that is not listed as a Covered Health Service under (Section 1: What's Covered--Benefits).

3. Procedures provided outside the Service Area except for Emergency Health Services and Covered Health Services received in Urgent Care Situations, unless approved by us.

4. Services from non-Network providers unless specifically authorized by us, except for Emergency Health Services and Covered Health Services received in Urgent Care Situations.

5. Confinement, treatment, services and supplies not recommended, approved or provided by a Physician.

6. Confinement, treatment, services and supplies rendered outside the scope of a provider’s license.

7. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Policy when:
   - Required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption.
   - Related to judicial or administrative proceedings or orders.
   - Conducted for purposes of medical research.
   - Required to obtain or maintain a license of any type.

8. Health 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.

9. Except as provided under the Extended Coverage for Total Disability provision in Section 8, health services received after the date your coverage under the Policy ends, including health...
services for medical conditions arising before the date your coverage under the Policy ends.

10. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy.

11. Charges in excess of Eligible Expenses or in excess of any specified limitation.

12. Deliveries that occur while the mother is outside the Service Area during the last trimester of Pregnancy, unless authorized by us.

13. Whole blood.

14. Upper and lower jawbone surgery except as required for direct treatment of temporomandibular disorder and/or related myofascial pain dysfunction syndrome, acute traumatic Injury, dislocation, tumors, or cancer.

15. Non-surgical treatment of obesity, including morbid obesity.

16. Surgical removal of excess skin and tissue resulting from weight loss (an example would be panniculectomy).

17. Abdominoplasty.

18. Reduction mammoplasty.

19. Growth hormone therapy.

20. Sex transformation operations.

21. Treatment of sexual dysfunction.

22. Custodial Care.

23. Domiciliary care.

24. Private duty nursing.

25. Respite care except as described in (Section 1: What's Covered--Benefits) under the heading Hospice Care.

26. Rest cures.

27. Psychosurgery.


29. Medical and surgical treatment of gynecomastia (abnormal breast enlargement in males).

30. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.


32. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, autism, a Congenital Anomaly or a "congenital or genetic birth defect" as described in (Section 10: Glossary of Defined Terms) under the definition of Habilitative Services. Speech therapy for stuttering/stammering.

33. Recreational activities that may be considered to serve a therapeutic purpose including, but not limited to, camp or camping events, sports or sporting events, horseback riding, art therapy services or art instruction, music therapy services or music instruction, boating or other recreational activities.

34. Services, therapy or supplies related to learning disabilities.

35. Physical, chiropractic, occupational or speech therapy determined no longer to be Medically Necessary or appropriate.

36. Inpatient cardiac rehabilitation.

37. Inpatient or day treatment programs for pain management.

38. Any charges for missed appointments, room or facility reservations, completion of claim forms or record processing.

39. Any charge for services, supplies or equipment advertised by the provider as free.

40. Any charges prohibited by federal anti-kickback or self-referral statutes.

41. 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: Obtaining Benefits

This section includes information about:
- Obtaining Benefits.
- Emergency Health Services.

Benefits
Benefits are payable for Covered Health Services which are any of the following:

- Provided by or under the immediate direction of your Primary Care Physician.
- For facility services, these are Benefits for Covered Health Services that are provided at a Network facility under the direction of either your Primary Care Physician or other Network Physician.
- Emergency Health Services.
- Covered Health Services received in Urgent Care Situations.
- Covered Health Services sought from a Network obstetrician/gynecologist or nurse midwife.
- Refractive eye examinations.

Benefits are not payable for Covered Health Services that are provided by non-Network providers except as specifically described below.

Selecting a Primary Care Physician
You must select a Primary Care Physician. Your Primary Care Physician will be responsible for coordinating all Covered Health Services and for ensuring continuity of care.

If you are the custodial parent of an Enrolled Dependent child, you must select a Primary Care Physician for that child.

Changing Primary Care Physicians
You may change your Primary Care Physician any time. To change your Primary Care Physician, log on to www.myuhc.com and follow the instructions to change your Primary Care Physician. Or, you may call Customer Service at the telephone number on your health plan identification card and ask to change your Primary Care Physician. Please note that the change will be effective the 1st of the month following the month in which the change request was received. And remember that if you have a referral from your current Primary Care Physician to a Specialist Physician, you will need a new referral from your new Primary Care Physician.

Provider Network
We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select 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.

You may request a directory of Network providers or view the current listing of Network providers on www.myuhc.com. 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 Customer Service.
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.

Do not assume that a Network provider’s agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health 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 assistance.

**Case Management Program**
The Case Management program is a collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates Medically Necessary Covered Health Services that are approved by your Physician. The program is designed to meet your health needs by employing all available resources to promote quality care and the most effective outcome.

**Referral Health Services**
All Covered Health Services must be provided by or coordinated through your Primary Care Physician. The only exceptions to this requirement are:

- Emergency Health Services.
- Out-of-area Urgent Care Situations.
- Covered Health Services sought from a Network obstetrician/gynecologist or nurse midwife.
- Refractive eye examinations.
- Obstetric and gynecological care Health Services that you choose to receive from a Network certified nurse-midwife or other Network provider authorized under Maryland law to provide obstetric and gynecological services.

If your Primary Care Physician is not able to provide a Covered Health Service, he or she will refer you to a Network specialist or other Network provider. Please note, however, that Benefits are not available for Covered Health Services that require a direct referral, unless you have obtained the appropriate referral from your Primary Care Physician.

In addition, you may request a referral to a non-Network specialist if all of the following apply:

- You are diagnosed with a condition or disease that requires specialized medical care; and
- We do not have a specialist in our Network with the professional training and expertise to treat the condition or disease; or
- We can not provide reasonable access to a Network specialist with the professional training and expertise to treat the condition or disease without unreasonable delay or travel.

Any service you receive in accordance with the above referral requirements to a non-Network specialist will carry the same deductible, Copayment or coinsurance payment as if the service was performed by a Network specialist.

In addition to these referral rules, state law requires a standing referral to Network Specialists in the following circumstances:

- The Covered Person’s Primary Care Physician determines, in consultation with the specialist, that the Covered Person needs continuing care from the specialist because of a condition or
disease that is life threatening, degenerative, chronic, or disabling and requires specialized medical care.

- The specialist must have expertise in treating the life-threatening, degenerative, chronic, or disabling disease or condition and be a Network Physician.

- The standing referral shall be made in accordance with a written treatment plan for a covered service developed by the Primary Care Physician, the Network specialist, and the Covered Person. The treatment plan may:
  — Limit the number of visits to the specialist.
  — Limit the period of time in which visits to the specialist are authorized.
  — Require the specialist to communicate regularly with the Primary Care Physician regarding the treatment and health status of the Covered Person.

- The Covered Person cannot be required to see a provider in addition to the Primary Care Physician before the standing referral is granted.

- Covered Persons who are pregnant shall receive a standing referral to a Network obstetrician who shall be responsible for the primary management of the Covered Person's Pregnancy, including the issuance of referrals in accordance with our policies and procedures, through the postpartum period. No treatment plan is required for standing referrals to an obstetrician.

Please Note: Other than those specific services described above as exceptions to this requirement, we will not pay for services you receive if you consult another Network Physician or other provider without a referral from your Primary Care Physician.

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from non-Network providers. In this situation, your Primary Care Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Primary Care Physician to coordinate care through a non-Network provider.

**Centers for Cardiac Surgery and Joint Replacement**

Centers for Cardiac Surgery and Joint Replacement are Network Hospitals that have demonstrated qualifications to perform a particular medical or surgical procedure, and which have agreed to act as a preferred center within a designated regional area. Covered Persons must receive the particular medical or surgical procedure at a designated Center for Cardiac Surgery and Joint Replacement.

The Centers for Cardiac Surgery and Joint Replacement are identified in the list of Network providers. You may also contact Customer Service for information about the programs available.

**Failure to Comply with Recommended Treatment (Second Opinion)**

Failure to comply with recommended treatment is your option. If you refuse to accept such a recommended treatment or procedure, you will be provided an opportunity to receive a second opinion from another Network Physician. Should the second Network Physician confirm the opinion of the original Network Physician, and you continue your refusal to accept the recommended treatment, we shall have no further responsibility to provide care for the Sickness or Injury under treatment, unless you later decide to follow your Primary Care Physician's recommended course of treatment.
Emergency Health Services

We provide Benefits for Emergency Health Services when required for stabilization and initiation of treatment as provided by or under the direction of a Physician.

We provide Benefits for Emergency Health Services even if you do not have a referral from your Primary Care Physician. Whenever possible, you should contact your Primary Care Physician before receiving Emergency Health Services, and then seek care from the Network provider he or she designates.

Benefits are paid for Emergency Health Services, even if the services are provided by a non-Network provider.

If you are confined in a non-Network Hospital after you receive Emergency Health Services, we must be notified 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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be available.

If Emergency Health Services provided by a non-Network provider include surgical services, you may elect to receive outpatient follow-up care from the non-Network provider 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 Primary Care Physician.

Care Outside Our Service Area

Benefits are provided for Covered Health Services provided to you if you have an Emergency or Urgent Care Situation under any of the following circumstances:

- You are traveling outside the Service Area.
- You have temporarily relocated outside the Service Area.
- You are a Full-time Student attending an accredited institution outside the Service Area.

In these circumstances, you must seek and receive care in compliance with the following requirements:

- Benefits are provided for Emergency Health Services, as defined in this Certificate and described above under Emergency Health Services.
- Benefits for Covered Health Services required as treatment in an Urgent Care Situation are also provided. An Urgent Care Situation is an unforeseen Sickness or Injury that is less severe than an Emergency medical condition, but requires timely medical care to prevent health deterioration, as determined by us. Should an Urgent Care Situation arise, seek care from a local doctor. If it is not possible to see a local doctor, you may then seek care from a Hospital emergency room. Follow-up care relating to an Urgent Care Situation should be provided by your Primary Care Physician. Benefits for follow-up care that are not provided by your Primary Care Physician will not be provided unless it has been determined, and authorized in advance by us, that it is not reasonably possible for you to return to the Service Area for follow-up treatment. When applicable, notify your Primary Care Physician before receiving health care services (including follow-up care) to determine if Benefits are available.
Section 4: When Coverage Begins

This section includes information about:
- How to enroll.
- If you are hospitalized when this coverage begins.
- Who is eligible for coverage.
- When to enroll.
- When coverage begins.

How to Enroll
To enroll, the Eligible Person must complete an enrollment form. The Enrolling Group will give the necessary forms to you. The Enrolling Group will then submit the properly completed forms to us, along with any required Premium. We will not provide Benefits for health services that you receive before your effective date of coverage.

If You Are Hospitalized When Your Coverage Begins
If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, we will pay Benefits for Covered Health Services related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Policy.

You should notify us within 48 hours of the day your coverage begins, or as soon as is reasonably possible. Benefits are available only if you receive Covered Health Services at a Network facility under the direction of your Primary Care Physician.
### Who is Eligible for Coverage

<table>
<thead>
<tr>
<th>Who</th>
<th>Description</th>
<th>Who Determines Eligibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligible Person</td>
<td>Eligible Person usually refers to an employee or member of the Enrolling Group who meets the eligibility rules. When an Eligible Person actually enrolls, we refer to that person as a Subscriber. For a complete definition of Eligible Person, Enrolling Group and Subscriber, see (Section 10: Glossary of Defined Terms).</td>
<td>We and the Enrolling Group determine who is eligible to enroll under the Policy.</td>
</tr>
<tr>
<td></td>
<td>Eligible Persons must reside or work within the Service Area, which is a specific geographic area that we serve.</td>
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<tr>
<td></td>
<td>Except as we have described in (Section 4: When Coverage Begins), Eligible Persons may not enroll.</td>
<td></td>
</tr>
<tr>
<td>Dependent</td>
<td>Dependent generally refers to the Subscriber's spouse and children. When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see (Section 10: Glossary of Defined Terms).</td>
<td>We and the Enrolling Group determine who qualifies as a Dependent.</td>
</tr>
<tr>
<td></td>
<td>Dependants of an Eligible Person may not enroll unless the Eligible Person is also covered under the Policy.</td>
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<tr>
<td></td>
<td>Except as we have described in (Section 4: When Coverage Begins), Dependents may not enroll.</td>
<td></td>
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</table>
### When to Enroll and When Coverage Begins

<table>
<thead>
<tr>
<th>When to Enroll</th>
<th>Who Can Enroll</th>
<th>Begin Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial Enrollment Period</strong></td>
<td>Eligible Persons may enroll themselves and their Dependents.</td>
<td>Coverage begins on the date identified in the Policy if we receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible to enroll.</td>
</tr>
<tr>
<td><strong>Open Enrollment Period</strong></td>
<td>Eligible Persons may enroll themselves and their Dependents.</td>
<td>We and the Enrolling Group determine the Open Enrollment Period. Coverage begins on the date identified by the Enrolling Group if we receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible to enroll.</td>
</tr>
<tr>
<td><strong>New Eligible Persons</strong></td>
<td>New Eligible Persons may enroll themselves and their Dependents.</td>
<td>Coverage begins on the date agreed to by the Enrolling Group and us if we receive the completed enrollment form and any required Premium within 31 days of the date the new Eligible Person first becomes eligible.</td>
</tr>
<tr>
<td><strong>Adding New Dependents</strong></td>
<td>Subscribers may enroll Dependents who join their family because of any of the following events:</td>
<td>The newborn child of the Subscriber or the Subscriber's spouse is covered automatically from the moment of birth for at least 31 days provided at least one family member other than the Subscriber is covered under the Policy at the time of the birth.</td>
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</tbody>
</table>
  - Birth.
  - Legal adoption.
  - Placement for adoption.
<table>
<thead>
<tr>
<th>When to Enroll</th>
<th>Who Can Enroll</th>
<th>Begin Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marriage.</td>
<td>The newly adopted child of the Subscriber or the Subscriber's spouse is covered automatically from the date of adoption for at least 31 days provided at least one family member other than the Subscriber is covered under the Policy on the date of adoption or placement for adoption. &quot;Date of adoption&quot; 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.</td>
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<tr>
<td>Legal guardianship.</td>
<td>The 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 provided at least one family member other than the Subscriber is covered under the Policy on the date of the court ordered custody.</td>
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<tr>
<td>Court or administrative order.</td>
<td>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.</td>
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<tr>
<td>Registering a Domestic Partner.</td>
<td>The child in the custody of the Subscriber or</td>
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### When to Enroll

<table>
<thead>
<tr>
<th>Event Takes Place</th>
<th>Begin Date</th>
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<tr>
<td>The Subscriber's spouse as a result of a guardianship of more than 12 months duration granted by court or testamentary appointment is covered automatically from the date of such appointment for at least 31 days provided at least one family member other than the Subscriber is covered under the Policy on the date of appointment.</td>
<td>The date of such appointment for at least 31 days.</td>
</tr>
<tr>
<td>If payment of a specific Premium or subscription fee is required to provide coverage for any of the above, we will require notification and payment of the required Premium or fees shall be furnished to us within 31 days after the date of birth, adoption, the court order or appointment in order to have coverage continued beyond the 31 day period, otherwise coverage will terminate at the end of the 31 day period.</td>
<td>The 31 days after the date of birth, adoption, the court order or appointment.</td>
</tr>
</tbody>
</table>

### Special Enrollment Period

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.
- Involuntary termination of spouse's coverage under another plan.
- A court order or the support enforcement event.

**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 was terminated for cause, or because premiums were not paid on a timely basis.**
### When to Enroll

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 elected.

### Who Can Enroll

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

- 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:
  - 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.
  - was not under a COBRA continuation provision, and either the coverage was terminated as a result of loss of eligibility for the coverage, including loss of eligibility as a result of such

### Begin Date

- Coverage begins on the day following such termination.
- If application and payment of Premium is made after 30 days, coverage under this plan begins on the date the application is received.

In any event, enrollment and payment of Premium for coverage under this plan must occur within 6 months of the date the prior coverage terminated.

**Missed Initial Enrollment Period or Open Enrollment Period.** Coverage begins on the day immediately following the day coverage under the prior plan ends if we receive the completed enrollment form and any required Premium within 31 days of the date coverage under the prior plan ended except when coverage under the prior plan ends due to meeting or exceeding a lifetime limit.

In that case, Coverage begins on the day immediately following the day coverage under the prior plan ends if we receive the completed enrollment form and any required Premium within 30 days of the date a claim is denied due to the operation of a lifetime limit on all benefits.
<table>
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<tr>
<th>When to Enroll</th>
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<tr>
<td>result of legal separation, divorce, death,</td>
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<td>termination of employment, or reduction in</td>
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<td>the number of hours of employment, or</td>
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<td>employer contributions towards the</td>
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<td>coverage were terminated.</td>
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<td>— The Eligible Person and/or Dependent no longer lives or works in an HMO</td>
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<td>service area if no other benefit option is available.</td>
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<tr>
<td>— The plan no longer offers benefits to a class of individuals that include</td>
</tr>
<tr>
<td>the Eligible Person and/or Dependent.</td>
</tr>
<tr>
<td>— An Eligible Person and/or Dependent incurs a claim that would meet or</td>
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<tr>
<td>exceed a lifetime limit on all benefits.</td>
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</table>

<table>
<thead>
<tr>
<th>Who Can Enroll</th>
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<tbody>
<tr>
<td>Begin Date</td>
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</table>
Section 5: How to File a Claim

This section provides you with information about:

- How and when to file a claim.
- If you receive Covered Health Services from a Network provider, you do not have to file a claim. We pay these providers directly.
- If you receive Covered Health Services from a non-Network provider, you are responsible for filing a claim.

If You Receive Covered Health Services from a Network Provider

There are generally no claim forms to complete when you receive Covered Health Services from Network providers. We pay Network providers directly for your Covered Health Services. This direct billing means no waiting for reimbursement and no concern about payment due dates. If a Network provider bills you for any Covered Health Service, contact us. However, you are responsible for Copayments to a Network provider at the time of service, or when you receive a bill for the Copayment from the provider.

If You Receive Covered Health Services from a Non-Network Provider

When you receive Covered Health Services from a non-Network provider as a result of an Emergency or if we refer you to a non-Network provider, you are responsible for requesting payment from us. You must submit to us an itemized bill with receipt(s). If the claim is for a Covered Health Service, which is covered under the Policy, your claim will be approved and the payment sent to you.

You must submit a request for payment of Benefits within one year of the date of service. In no event, however, will a claim be processed later than one year from the time proof of loss is otherwise required, except in the absence of legal capacity. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Reimbursement of Excess Copayments

The amount you are required to pay in Copayments is limited as stated in the Out-of-Pocket Maximum explanation in (Section 1: What's Covered--Benefits). Because Copayments are paid directly to the Network provider, we may not know that you have exceeded the Out-of-Pocket Maximum. We will reimburse the Subscriber for Copayments for Benefits paid that exceed the Out-of-Pocket Maximum stated in (Section 1: What's Covered--Benefits).

To be reimbursed for excess Copayments, the Subscriber must notify us in writing that excess Copayments have been paid. We must receive this notice no later than 90 days after the end of the calendar year. The notification must include proof of the payment of all Copayments, such as a cancelled check or a receipt from the provider.
Payment of Claims
All Benefits payable under the Certificate will be paid not more than thirty (30) days after receipt of written proof of loss.
Section 6: Questions, Complaints, and Appeals

Member concerns and inquiries can generally be resolved by contacting Customer Service. Inquiries and general concerns will be resolved within ten (10) calendar days of the receipt of your inquiry.

You are entitled to submit to OCI a formal statement of dissatisfaction on any matter that may be in dispute, and request a review. In order to request a review, you must submit your written request to the OCI Customer Support Group, P.O. Box 933, Frederick, Maryland 21705 within one hundred eighty (180) calendar days of the incident in question. OCI will send to you a written response within thirty (30) calendar days of receipt of your request.

If you are not satisfied after OCI's formal grievance procedure is completed or if you have a concern regarding the operation of OCI's health plan, you may contact the State of Maryland's Insurance Commissioner at:

Maryland Insurance Administration
Inquiry and Investigation
Life and Health
525 St. Paul Place
Baltimore, Maryland 21202-2272

Note: The grievance procedure described above does not apply to an Adverse Decision or Coverage Decision.

GRIEVANCE PROCEDURE FOR ADVERSE DECISIONS

The following terms appearing below are defined as follows:

- **Adverse Decision** - a utilization review determination by a private review agent, a carrier, or a health care provider acting on behalf of a carrier that:
  - A proposed or delivered health care service covered under the member's contract is or was not medically necessary, appropriate, or efficient; and
  - May result in noncoverage of the health care service.

Adverse Decision does not include a decision concerning a subscriber's status as a member.

- **Filing date** - the earlier of:
  - (a) 5 days after the date of mailing; or
  - (b) The date of receipt.

- **Grievance** - a protest filed by a member or a health care provider on behalf of a member with a carrier through the carrier's internal grievance process regarding an Adverse Decision concerning the member.

- **Grievance Decision** - a final determination by a carrier that arises from a grievance filed with the carrier under its internal grievance process regarding an Adverse Decision concerning a member.

- **Health care provider**
  - (a) An individual who is:
(i) Licensed or otherwise authorized in this State to provide health care services in the ordinary course of business or practice of a profession, and
(ii) A treating provider of a member; or
(b) A hospital, as defined in Health-General Article, §19-301, Annotated Code of Maryland.

We maintain a formal Grievance procedure if you are not satisfied with an Adverse Decision. You, your representative, or a health care provider acting on your behalf may file a Grievance regarding an Adverse Decision. The notice of and Adverse Decision will be sent within five (5) working days after the Adverse Decision is made and will state, among other things, the name and address of the Medical Director who made the Adverse Decision. The following is the address and telephone number of the medical director responsible for adverse decisions: Medical Director, OCI, 4 Taft Court, Rockville, Maryland 20850; Telephone: 301/545-5780.

A health care provider should call the Professional Services Department and you or your representative should call Customer Service at the phone number on your identification card for information on how to submit a Grievance. Grievances for an Adverse Decision should be directed to the Customer Support Group, Member Services, P.O. Box 933, Frederick, Maryland 21705. Grievances cannot be taken verbally. The Grievance must be filed within one hundred eighty (180) calendar days after the receipt of the Adverse Decision.

A. All Grievances regarding Adverse Decisions are formally recorded and acknowledged. With the exception of emergency cases, we will send you, your representative, or a health care provider acting on your behalf a letter that details the Grievance process within five (5) working days after your initial contact with us regarding an Adverse Decision. Please take note of the following, as it relates to the Grievance procedure for Adverse Decisions:

1. The Maryland Health Advocacy Unit (HAU) is available to assist you, your representative, or a health care provider acting on your behalf with filing a Grievance under OCI's Grievance procedures, but is not available to represent or accompany you during the proceedings and can assist you in mediating a resolution of the Adverse Decision with us, although you, your representative, or a health care provider acting on your behalf, may file a Grievance at any time.

2. You, your representative, or a health care provider acting on your behalf may file a complaint with the Commissioner of the Maryland Insurance Administration without first filing a Grievance with us if you can demonstrate that there is a compelling reason to do so.

3. The following is the address, telephone number and fax number for the Maryland Insurance Administration:

   Maryland Insurance Administration
   Appeals and Grievance Unit
   Maryland Insurance Administration
   P.O. Box 933
   Frederick, Maryland 21705

   Telephone: 301/545-5780; Fax #: 301/545-5781

   Website address: www.oag.state.md.us
B. We will reach a final decision and notify you, your representative, or a health care provider acting on your behalf of said decision within thirty (30) calendar days after the Filing Date. We will communicate the Grievance Decision in writing after we have provided oral communication of the decision to you, your representative, or the health care provider who filed a Grievance on your behalf, and send, within five (5) working days, a written notice to you, your representative and the health care provider who filed a Grievance on your behalf that:

1. States in detail in clear, understandable language the specific factual basis for our decision.
2. References the specific criteria and standards, including interpretive guidelines, on which the Grievance Decision was based.
3. States the name, business address, and business telephone number of the Medical Director who rendered the Grievance Decision.
4. Includes the following information:
   a. That you, your representative or the health care provider acting on your behalf, have a right to file a complaint with the Insurance Commissioner within thirty (30) working days after receipt of our Grievance Decision.
   b. The Insurance Commissioner's address, telephone number, and facsimile number.

C. In the event we do not have sufficient information to complete the Grievance process, we will notify you, your representative, or a health care provider who filed a Grievance on your behalf within five (5) working days from the date you, your representative or a health care provider on your behalf filed a Grievance with us. We will assist in gathering the necessary information needed to reach a decision within the time allowed. If you, your representative, or a health care provider acting on your behalf have not received a Grievance Decision on or before the thirtieth (30th) calendar day after the Filing Date, you, your representative, or a health care provider acting on your behalf, may file a complaint with the Maryland Insurance Commissioner.

D. An expedited review procedure of a Grievance is available for emergency cases. An emergency case is a case in which services are necessary to treat a condition or illness that, without immediate medical attention, would seriously jeopardize your life or health or your ability to regain maximum function, or would cause you to be a danger to self or others as determined by OCI's Medical Director. The determination about the existence of an emergency case will be done on a case-by-case basis based on the definition set forth herein.

In the event a Grievance qualifies as an emergency case, we will reach a final decision within twenty-four (24) hours of the Filing Date. The decision will be orally communicated to you, your representative, or a health care provider who filed a Grievance on your behalf. Within one (1) calendar day after the final decision has been orally communicated to you, your representative, or the health care provider who filed the Grievance on your behalf, we will send written notification of this decision to you, your representative and the health care provider who filed a Grievance on your behalf. The notification shall contain the information outlined in the Grievance Decision notice above. If we do not have sufficient information to complete the Grievance process in a case in which you, your representative, or a health care provider on your behalf asserts...
that an emergency exists, we will notify you, your representative or the health care provider acting on your behalf by telephone, fax or other expeditious means and similarly contact other applicable providers for additional information. In any event, we will render a decision within twenty-four (24) hours.

If you, your representative, or a health care provider on your behalf have not received a Grievance Decision within twenty-four (24) hours with respect to an Emergency Case, you, your representative, or the health care provider acting on your behalf, may file a complaint with the Maryland Insurance Commissioner.

E. If you, your representative, or a health care provider who filed a Grievance on your behalf are not satisfied with a Grievance Decision, you, your representative or the health care provider acting on your behalf may file a complaint with the Maryland Insurance Commissioner within thirty (30) working days of receipt of the Grievance Decision from us. You, your representative, or the health care provider acting on your behalf may file a complaint with the Maryland Insurance Commissioner without first filing a formal Grievance with us if there is a compelling reason to do so.

PROCEDURE FOR A COVERAGE DECISION

The following terms appearing below are defined as follows:

Appeal - a protest filed by a member or a health care provider with a carrier under its internal appeal process regarding a coverage decision concerning a member.

Appeal Decision - a final determination by a carrier that arises from an appeal filed with the carrier under its appeal process regarding a coverage decision concerning a member.

Coverage Decision - an initial determination by a carrier or a representative of the carrier that results in noncoverage of a health care service.

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 Customer Service at 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 send you, your representative, or a health care provider acting on your behalf a written response to your Appeal within thirty (30) calendar days of our receipt of your Appeal.

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 sixty (60) working days 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 525 St. Paul Place, Baltimore, MD 21202, phone (410) 468-2000, toll free (800) 492-6116 or facsimile (410) 468-2270.

You, your representative, or a health care provider acting on your behalf may contact the Health Education Advocacy Unit of the Attorney Generals Office of Maryland's Consumer Protection Division at:

Health Education Advocacy Unit
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 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 Coordination of Benefits Applies
This coordination of benefits (COB) provision applies when a person has health care coverage under more than one benefit plan.

The order of benefit determination rules described in this section determine which Coverage Plan will pay as the Primary Coverage Plan. The Primary Coverage Plan that pays first pays without regard to the possibility that another Coverage Plan may cover some expenses. A Secondary Coverage Plan pays after the Primary Coverage Plan and may reduce the benefits it pays. This is to prevent payments from all group Coverage Plans from exceeding 100 percent of the total Allowable Expense.

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

1. "Coverage Plan" is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Coverage Plan and there is no COB among those separate contracts.
   a. "Coverage Plan" includes: group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured); medical care components of group long-term care contracts, such as skilled nursing care; and Medicare or other governmental benefits, as permitted by law.
   b. "Coverage Plan" does not include: individual or family insurance; closed panel or other individual coverage (except for group-type coverage); school accident type coverage; benefits for non-medical components of group long-term care policies; Medicare supplement policies, Medicaid policies and coverage under other governmental plans, unless permitted by law.

Each contract for coverage under a. or b. above is a separate Coverage Plan. If a Coverage Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Coverage Plan.
2. The order of benefit determination rules determine whether this Coverage Plan is a "Primary Coverage Plan" or "Secondary Coverage Plan" when compared to another Coverage Plan covering the person.

When this Coverage Plan is primary, its benefits are determined before those of any other Coverage Plan and without considering any other Coverage Plan's benefits. When this Coverage Plan is secondary, its benefits are determined after those of another Coverage Plan and may be reduced because of the Primary Coverage Plan's benefits.

3. "Allowable Expense" means a health care service or expense, including deductibles and copayments that is covered at least in part by any of the Coverage Plans covering the person. When a Coverage Plan provides benefits in the form of services, (for example an HMO) the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense or service that is not covered by any of the Coverage Plans is not an Allowable Expense. Dental care, routine vision care, outpatient prescription drugs, and hearing aids are examples of expenses or services that are not Allowable Expenses under the Policy. The following are additional examples of expenses or services that are not Allowable Expenses:
   a. If a Covered Person is confined in a private Hospital room, the difference between the cost of a semi-private room in the Hospital and the private room, (unless the patient's stay in a private Hospital room is medically necessary in terms of generally accepted medical practice, or one of the Coverage Plans routinely provides coverage for Hospital private rooms) is not an Allowable Expense.
   b. If a person is covered by two or more Coverage Plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an Allowable Expense.
   c. If a person is covered by two or more Coverage 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.
   d. If a person is covered by one Coverage Plan that calculates its benefits or services on the basis of usual and customary fees and another Coverage Plan that provides its benefits or services on the basis of negotiated fees, the Primary Coverage Plan's payment arrangements shall be the Allowable Expense for all Coverage Plans.
   e. The amount a benefit is reduced by the Primary Coverage Plan because a Covered Person does not comply with the Coverage Plan provisions. Examples of these provisions are second surgical opinions and precertification of admissions.

4. "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under this Coverage Plan, or before the date this COB provision or a similar provision takes effect.

5. "Closed Panel Plan" is a Coverage Plan that provides health benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Coverage Plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

6. "Custodial Parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.
Order of Benefit Determination Rules
When two or more Coverage Plans pay benefits, the rules for determining the order of payment are as follows:

A. The Primary Coverage Plan pays or provides its benefits as if the Secondary Coverage Plan or Coverage Plans did not exist.

B. A Coverage Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: 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 the supplementary coverage shall be excess to any other parts of the Coverage Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base Coverage Plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel Coverage Plan to provide out-of-network benefits.

C. A Coverage Plan may consider the benefits paid or provided by another Coverage Plan in determining its benefits only when it is secondary to that other Coverage Plan.

D. The first of the following rules that describes which Coverage Plan pays its benefits before another Coverage Plan is the rule to use.

1. Non-Dependent or Dependent. The Coverage Plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the Coverage Plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Coverage Plan covering the person as a dependent; and primary to the Coverage Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Coverage Plans is reversed so that the Coverage Plan covering the person as an employee, member, subscriber or retiree is secondary and the other Coverage Plan is primary.

2. Child Covered Under More Than One Coverage Plan. The order of benefits when a child is covered by more than one Coverage Plan is:

a. The Primary Coverage Plan is the Coverage Plan of the parent whose birthday is earlier in the year if:
   1) The parents are married;
   2) The parents are not separated (whether or not they ever have been married); or
   3) A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

   If both parents have the same birthday, the Coverage Plan that covered either of the parents longer is primary.

b. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the Coverage Plan of that parent has actual knowledge of those terms, that Coverage Plan is primary. This rule applies to Claim Determination Periods or plan years commencing after the Coverage Plan is given notice of the court decree.

c. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
   1) The Coverage Plan of the custodial parent;
   2) The Coverage Plan of the spouse of the custodial parent;
   3) The Coverage Plan of the noncustodial parent; and then

To continue reading, go to right column on this page.

To continue reading, go to left column on next page.
4) The Coverage Plan of the spouse of the noncustodial parent.

3. Active or Inactive Employee. The Coverage Plan that covers a person as an employee who is neither laid off nor retired is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other Coverage Plan does not have this rule, and if, as a result, the Coverage Plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined under the rule labeled D.1.

4. Continuation Coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another Coverage Plan, the Coverage Plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other Coverage Plan does not have this rule, and if, as a result, the Coverage Plans do not agree on the order of benefits, this rule is ignored.

5. Longer or Shorter Length of Coverage. The Coverage Plan that covered the person as an employee, member, subscriber or retiree longer is primary.

6. If a husband or wife is covered under this Coverage Plan as a Subscriber and as an Enrolled Dependent, the dependent benefits will be coordinated as if they were provided under another Coverage Plan, this means the Subscriber's benefit will pay first.

7. If the preceding rules do not determine the Primary Coverage Plan, the Allowable Expenses shall be shared equally between the Coverage Plans meeting the definition of Coverage Plan under this provision. In addition, this Coverage Plan will not pay more than it would have paid had it been primary.

E. A homeowner's policy that provides medical benefits coverage shall provide primary coverage.

Effect on the Benefits of this Plan

A. When this Coverage Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Coverage Plans during a Claim Determination Period are not more than 100 percent of total Allowable Expenses. The difference between the benefit payments that this Coverage Plan would have paid had it been the Primary Coverage Plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the Covered Person and used by this Coverage Plan to pay any Allowable Expenses, not otherwise paid during the Claim Determination Period. As each claim is submitted, this Coverage Plan will:

1. Determine its obligation to pay or provide benefits under its contract;
2. Determine whether a benefit reserve has been recorded for the Covered Person; and
3. Determine whether there are any unpaid Allowable Expenses during that Claim Determination Period.

If there is a benefit reserve, the Secondary Coverage Plan will use the Covered Person's benefit reserve to pay up to 100 percent of total Allowable Expenses incurred during the Claim Determination Period. At the end of the Claim Determination Period, the benefit reserve returns to zero. A new benefit reserve must be created for each new Claim Determination Period.

B. If a Covered Person is enrolled in two or more closed panel Coverage Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one
closed panel Coverage Plan, COB shall not apply between that Coverage Plan and other closed panel Coverage 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 Coverage Plan and other Coverage 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 Coverage Plan and other Coverage 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 Coverage 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 Coverage Plan may include an amount that should have been paid under this Coverage 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 Coverage 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.

**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: When Coverage Ends

This section provides you with information about all of the following:
- Events that cause coverage to end.
- The date your coverage ends.
- Continuation of coverage under federal law (COBRA) and under state law.
- Conversion.

General Information about When Coverage Ends

We may discontinue this benefit plan and/or all similar benefit plans at any time for the reasons explained in the Policy, as permitted by law. In the event that this coverage ends, we will forward a notice of termination to you not less than thirty (30) days before the date of cancellation in accordance with Maryland Regulation 31.12.02.10D.

Your entitlement 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 *Extended Coverage for Total Disability*.

When your coverage ends, we will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, we do not provide Benefits for health services that you receive for medical conditions that occurred before your coverage ended except as noted below under *Extended Coverage for Total Disability*.

An Enrolled Dependent's coverage ends on the date the Subscriber's coverage ends.
Events Ending Your Coverage

Coverage ends on the earliest of the dates specified in the following table:

<table>
<thead>
<tr>
<th>Ending Event</th>
<th>What Happens</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The Entire Policy Ends</strong></td>
<td>Your coverage ends on the date the Policy ends. The Enrolling Group is responsible for notifying you that your coverage has ended.</td>
</tr>
<tr>
<td><strong>You No Longer Reside or Work in Service Area</strong></td>
<td>Your coverage ends on the last day of the calendar month in which you no longer reside or work in the Service Area. Coverage will end on the date of that move, even if you do not notify us. (This does not apply to an Enrolled Dependent child for whom the Subscriber is required to provide health insurance coverage through a Qualified Medical Child Support Order or other court or administrative order.) The Subscriber or the Enrolling Group must notify us if you move from the Service Area.</td>
</tr>
<tr>
<td><strong>You Are No Longer Eligible</strong></td>
<td>Your coverage ends on the last day of the calendar month in which you are no longer eligible to be a Subscriber or Enrolled Dependent or on the last day of the calendar month in which we receive written notice from the Enrolling Group instructing us to end your coverage, if later. Please refer to (Section 10: Glossary of Defined Terms) for a more complete definition of the terms &quot;Eligible Person&quot;, &quot;Subscriber&quot;, &quot;Dependent&quot; and &quot;Enrolled Dependent.&quot;</td>
</tr>
<tr>
<td><strong>We Receive Notice to End Coverage</strong></td>
<td>Your coverage ends on the last day of the calendar month in which we receive written notice from the Enrolling Group instructing us to end your coverage, or the date requested in the notice, if later. The Enrolling Group is responsible for providing written notice to us to end your coverage.</td>
</tr>
<tr>
<td><strong>Subscriber Retires or Is Pensioned</strong></td>
<td>Your coverage ends the last day of the calendar month in which the Subscriber is retired or pensioned under the Enrolling Group's plan. The Enrolling Group is responsible for providing written notice to us to end your coverage. This provision applies unless a specific coverage classification is designated for retired or pensioned persons in the Enrolling Group's application, and only if the Subscriber continues to meet any applicable eligibility requirements. The Enrolling Group can provide you with specific information about what coverage is continued.</td>
</tr>
<tr>
<td>Ending Event</td>
<td>What Happens</td>
</tr>
<tr>
<td>--------------</td>
<td>--------------</td>
</tr>
<tr>
<td></td>
<td>available for retirees.</td>
</tr>
</tbody>
</table>
Other Events Ending Your Coverage

When any of the following happen, we will provide written notice to the Subscriber that coverage has ended on the date we identify in the notice:

<table>
<thead>
<tr>
<th>Ending Event</th>
<th>What Happens</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fraud, Misrepresentation or False Information</td>
<td>Fraud or intentional misrepresentation, or because the Subscriber knowingly gave us false material information. Examples include false information relating to residence and/or employment within the Service Area, or false information relating to another person's eligibility or status as a Dependent. During the first two years the Policy is in effect, 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.</td>
</tr>
<tr>
<td>Improper Use of ID Card</td>
<td>You permitted an unauthorized person to use your ID card, or you used another person's card.</td>
</tr>
<tr>
<td>Failure to Pay</td>
<td>You failed to pay a required Copayment. (If the Copayment is received prior to the date of termination, coverage will not be terminated.)</td>
</tr>
<tr>
<td>Threatening Behavior</td>
<td>You committed acts of physical or verbal abuse that pose a threat to our staff, a provider, or other Covered Persons.</td>
</tr>
</tbody>
</table>
Extended Coverage for Total Disability
A temporary extension of coverage will be granted to a Covered Person who is totally disabled on the date the Covered Person's coverage terminates. Benefits will be paid until the earliest of:

- The date the Total Disability ends.
- The date the Covered Person obtains coverage under another health care plan which provides treatment for the disabling condition, provided that such coverage is both of the following:
  - Provided at a cost that is less than or equal to the cost of this Extended Coverage for Total Disability; and
  - Does not result in an interruption of benefits.
- The date 12 months from the date coverage under the Policy would otherwise have terminated.

No Premium will be charged for this extended coverage.

Continuation of Coverage and Conversion
If your coverage ends under the Policy, you may be entitled 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 Enrolling Groups that are subject to the terms of COBRA. You can contact your plan administrator to determine if your Enrolling Group is subject to the provisions of COBRA.

If you selected continuation coverage under a prior plan which was then replaced by coverage under this Policy, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed below, whichever is earlier.

We are not the Enrolling 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 Enrolling Group or its plan administrator fails to perform its responsibilities under federal law. Examples of the responsibilities of the Enrolling 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 Coverage under Federal Law (COBRA)
Much of the language in this section comes from the federal law that governs continuation coverage. You should call your Enrolling Group's plan administrator if you have questions about your right to continue coverage.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who was covered under the Policy on the day before a qualifying event:

- A Subscriber.
- A Subscriber's Enrolled Dependent, including with respect to the Subscriber's children, a child born to or placed for adoption with the Subscriber during a period of continuation coverage under federal law.
• A Subscriber's former spouse.

Qualifying Events for Continuation Coverage under Federal Law (COBRA)
If the coverage of a Qualified Beneficiary would ordinarily terminate due to one of the following qualifying events, then the Qualified Beneficiary is entitled to continue coverage. The Qualified Beneficiary is entitled to elect the same coverage that she or he had on the day before the qualifying event.

The qualifying events with respect to an employee who is a Qualified Beneficiary are:

A. Termination of the Subscriber from employment with the Enrolling Group, for any reason other than gross misconduct.
B. Reduction in the Subscriber's hours of employment.

With respect to a Subscriber's spouse or dependent child who is a Qualified Beneficiary, the qualifying events are:

A. Termination of the Subscriber from employment with the Enrolling Group, for any reason other than the Subscriber's gross misconduct.
B. Reduction in the Subscriber's hours of employment.
C. Death of the Subscriber.
D. Divorce or legal separation of the Subscriber.
E. Loss of eligibility by an Enrolled Dependent who is a child.
F. Entitlement of the Subscriber to Medicare benefits.
G. The Enrolling Group filing for bankruptcy, under Title 11, United States Code. This is also a qualifying event for any retired Subscriber and his or her Enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

Notification Requirements and Election Period for Continuation Coverage under Federal Law (COBRA)

Notification Requirements for Qualifying Event
The Subscriber or other Qualified Beneficiary must notify the Enrolling Group's plan administrator within 60 days of the latest of the date of the following events:

• The Subscriber's divorce or legal separation, or an Enrolled Dependent's loss of eligibility as an Enrolled Dependent.
• The date the Qualified Beneficiary would lose coverage under the Policy.
• The date on which the Qualified Beneficiary is informed of his or her obligation to provide notice and the procedures for providing such notice.

The Subscriber or other Qualified Beneficiary must also notify the Enrolling Group's plan administrator when a second qualifying event occurs, which may extend continuation coverage.

If the Subscriber or other Qualified Beneficiary fails to notify the Enrolling Group's plan administrator of these events within the 60-day period, the plan administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If a Subscriber is continuing coverage under federal law, the Subscriber must notify the Enrolling Group's plan administrator within 60 days of the birth or adoption of a child.
Notification Requirements for Disability Determination or Change in Disability Status

The Subscriber or other Qualified Beneficiary must notify the Enrolling Group's plan administrator as described under "Terminating Events for Continuation Coverage under Federal Law (COBRA)," subsection A below.

The notice requirements will be satisfied by providing written notice to the Enrolling Group's plan administrator at the address stated in the ERISA Statement. The contents of the notice must be such that the plan administrator is able to determine the covered employee and qualified beneficiary or beneficiaries, the qualifying event or disability, and the date on which the qualifying event occurred.

None of the above notice requirements will be enforced if the Subscriber or other Qualified Beneficiary is not informed of his or her obligations to provide such notice.

After providing notice to the Enrolling Group's plan administrator, the Qualified Beneficiary shall receive the continuation coverage and election notice. Continuation coverage must be elected by the later of 60 days after the qualifying event occurs; or 60 days after the Qualified Beneficiary receives notice of the continuation right from the plan administrator.

The Qualified Beneficiary's initial premium due to the plan administrator must be paid on or before the 45th day after electing continuation.

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain employees who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If you qualify or may qualify for assistance under the Trade Act of 1974, contact the Enrolling Group for additional information. You must contact the Enrolling Group promptly after qualifying for assistance under the Trade Act of 1974 or you will lose your special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that plan coverage was lost but begins on the first day of the special second election period.

Terminating Events for Continuation Coverage under Federal Law (COBRA)

Continuation under the Policy will end on the earliest of the following dates:

A. Eighteen months from the date of the qualifying event, if the Qualified Beneficiary's coverage would have ended because the Subscriber's employment was terminated or hours were reduced (i.e., qualifying event A).

If a Qualified Beneficiary is determined to have been disabled under the Social Security Act at anytime within the first 60 days of continuation coverage for qualifying event A then the Qualified Beneficiary may elect an additional eleven months of continuation coverage (for a total of twenty-nine months of continued coverage) subject to the following conditions:
Notice of such disability must be provided within the latest of 60 days after:

- the determination of the disability; or
- the date of the qualifying event; or
- the date the Qualified Beneficiary would lose coverage under the Policy; and
- in no event later than the end of the first eighteen months.

The Qualified Beneficiary must agree to pay any increase in the required Premium for the additional eleven months.

If the Qualified Beneficiary who is entitled to the eleven months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional eleven months of continuation coverage.

Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

B. Thirty-six months from the date of the qualifying event for an Enrolled Dependent whose coverage ended because of the death of the Subscriber, divorce or legal separation of the Subscriber, or loss of eligibility by an Enrolled Dependent who is a child (i.e. qualifying events C, D, or E).

C. With respect to Qualified Beneficiaries, and to the extent that the Subscriber was entitled to Medicare prior to the qualifying event:

- Eighteen months from the date of the Subscriber's Medicare entitlement; or

- Thirty-six months from the date of the Subscriber's Medicare entitlement, if a second qualifying event (that was due to either the Subscriber's termination of employment or the Subscriber's work hours being reduced) occurs prior to the expiration of the eighteen months.

D. With respect to Qualified Beneficiaries, and to the extent that the Subscriber became entitled to Medicare subsequent to the qualifying event:

- Thirty-six months from the date of the Subscriber's termination from employment or work hours being reduced (first qualifying event) if:
  - The Subscriber's Medicare entitlement occurs within the eighteen month continuation period; and
  - Absent the first qualifying event, the Medicare entitlement would have resulted in a loss of coverage for the Qualified Beneficiary under the group health plan.

E. The date coverage terminates under the Policy for failure to make timely payment of the Premium.

F. The date, after electing continuation coverage that coverage is first obtained under any other group health plan. If such coverage contains a limitation or exclusion with respect to any preexisting condition, continuation shall end on the date such limitation or exclusion ends. The other group health coverage shall be primary for all health services except those health services that are subject to the preexisting condition limitation or exclusion.

G. The date, after electing continuation coverage, that the Qualified Beneficiary first becomes entitled to Medicare, except that this shall not apply in the event that coverage was terminated because the Enrolling Group filed for bankruptcy, (i.e. qualifying event G). If the Qualified Beneficiary was entitled to continuation because the Enrolling Group filed for bankruptcy,
(i.e. qualifying event G) and the retired Subscriber dies during the continuation period, then the other Qualified Beneficiaries shall be entitled to continue coverage for thirty-six months from the date of the Subscriber's death.

H. The date the entire Policy ends.

1. The date coverage would otherwise terminate under the Policy as described earlier in this section under the heading Events Ending Your Coverage.

Continuation of Coverage under State Law for Surviving Spouses and Children

An Enrolled Dependent whose coverage under the Policy would otherwise terminate 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 Enrolling 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 Enrolling Group) for a period of at least 30 days prior to his or her death.

If the Enrolled Dependent spouse or child wish to continue coverage, he or she must request that the Enrolling Group provide an election notification form. Within 14 days of the receipt of the request, the Enrolling 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 Enrolling Group.

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

- Eighteen (18) months after the date continuation coverage began.
- The date coverage would otherwise terminate as described above under Events Ending your Coverage.
- The date coverage terminates for failure to make timely payment of the Premium.
- The date the Policy ends.
- 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 terminate coverage.

Continuation of Coverage under State Law for Divorced Spouses and Children

An Enrolled Dependent whose coverage under the Policy would otherwise terminate 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 terminated due to divorce.

If the Enrolled Dependent spouse or child wish to continue coverage, he or she or the Subscriber must notify the Enrolling Group of the divorce. This notification must be provided not later than described below.

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• 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 Enrolling Group. In this case coverage will be effective retroactive to the date of the applicable change in status.

• 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 be retroactive to the date of eligibility.

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

Continued Coverage shall terminate on the earlier of the following dates:

• The date coverage would otherwise terminate as described above under Events Ending Your Coverage.

• The date the Policy ends.

• 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 Enrolled Dependent spouse remarries.

• The date the Covered Person elects to terminate coverage. In order to terminate coverage, the Subscriber and Enrolled Dependent spouse must jointly sign a termination statement or the Subscriber must provide the Enrolling 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 terminate 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 Enrolling 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 Enrolling Group provide an election notification form. Within 14 days of the receipt of the request, the Enrolling 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 Enrolling Group.

Continued Coverage shall terminate on the earlier of the following dates:

• Eighteen (18) months after the date continuation coverage began.

• The date coverage would otherwise terminate as described above under Events Ending Your Coverage.
• The date coverage terminates for failure to make timely payment of the Premium.
• The date the Policy ends.
• 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 terminate coverage.

Conversion
If your coverage terminates for any reason other than those listed below, you may apply for conversion coverage without furnishing evidence of insurability.

Conversion is not available to a Subscriber whose coverage terminates for any of the following reasons:

• Inability of the medical staff and the Subscriber to establish a reasonable physician-patient relationship;
• Fraudulent use of the HMO's identification card by the Subscriber;
• The alteration or sale of prescriptions by the Subscriber;
• An attempt by the Subscriber to enroll noneligible persons as dependents;
• Failure of the Subscriber to pay any premium charge when due;
• Failure of the Subscriber to pay any deductible or copayment charges;

• The Subscriber no longer resides, lives, or works in the service area;
• The Subscriber has performed an act or practice that constitutes fraud; or
• The Subscriber has made an intentional misrepresentation of material fact under an application for HMO coverage.
• The Subscriber is enrolled in another HMO;
• The Subscriber is covered or eligible for coverage under a group health benefit plan as defined in Insurance Article, §15-1401, Annotated Code of Maryland; or
• The Subscriber is covered under an individual health benefit plan as defined in Insurance Article, §15-1301, Annotated Code of Maryland.

Application and payment of the initial Premium must be made within 31 days after coverage ends under this Policy or within 31 days of the date we notify you of your right to convert, whichever is later. Conversion coverage will be issued in accordance with the terms and conditions in effect at the time of application. Conversion coverage may be substantially different from coverage provided under this Policy.

We may designate a carrier to provide conversion coverage if you no longer reside within the Service Area and if you cease to be eligible for coverage under the Policy because:

• For the Subscriber, both your residence and employment are no longer in the Service Area.
• For an Enrolled Dependent, your residence is no longer in the Service Area.
• You cease to be eligible as a Subscriber or Enrolled Dependent.
Application to convert coverage effective on the date of termination, without furnishing evidence of insurability, must be made to our designated carrier within 31 days after end of coverage under the Policy. A conversion contract may be issued in accordance with the terms and conditions that the designated carrier has in effect at the time of application. Conversion coverage may be substantially different from Benefits available under the Policy.
Section 9: General Legal Provisions

This section provides you with information about:

- General legal provisions concerning the Policy.

Your Relationship with Us

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how we interact with your Enrolling Group’s benefit plan and how it may affect you. We help finance or administer the Enrolling Group’s benefit plan in which you are enrolled. We do not provide medical services. This means that we communicate to you decisions about whether the Enrolling Group’s benefit plan will cover or pay for the health care that you may receive. The plan pays for certain medical costs, which are more fully described in this Certificate. The plan may not pay for all treatments you or your Physician may believe are necessary. If the plan does not pay, you will be responsible for the cost.

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.

Circumstances Beyond Our Control

To the extent that a national disaster, riot, civil insurrection, epidemic or any other emergency or similar event not within the Health Plan’s control results in the Health Plan facilities, personnel or resources being unavailable to provide or arrange for the care and services it agreed to provide, the Health Plan is required only to make a good faith effort to provide or arrange for such care and services, taking into account the impact of the event. In such an event, the Health Plan will provide coverage for those expenses deemed Medically Necessary by a Participating Provider or the Health Plan’s Medical Director and to the extent prescribed by the Maryland Insurance Commissioner. For the purpose of this section, an event is not within the Health Plan’s control if the Health Plan cannot exercise influence or dominion over its occurrence.

Our Relationship with Providers and Enrolling Groups

The relationships between us and Network providers and Enrolling Groups are solely contractual relationships between independent contractors. Network providers and Enrolling Groups are not our agents or employees. Neither we nor any of our employees are agents or employees of Network providers or the Enrolling Groups.

We do not provide health care services or supplies, nor do we practice medicine. Instead, 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, but does not assure the quality of the services provided. They are not our employees nor do we have any other relationship with Network providers such as
principal-agent or joint venture. We are not liable 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 Enrolling Group’s benefit plan. We are not responsible for fulfilling any duties or obligations of an employer with respect to the Enrolling Group’s benefit plan.

The Enrolling 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 the termination of the Policy.

When the Enrolling 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 Enrolling 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.

Your Relationship with Providers and Enrolling Groups
The relationship between you and any provider is that of provider and patient.

- You are responsible for choosing your own provider.
- You must decide if any provider treating you is right for you. This includes Network providers you choose and providers to whom you have been referred.
- You must decide 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 Enrolling 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 Enrolling Group, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Enrolling Group is responsible for giving notice to you.

Statements by Enrolling Group or Subscriber
All statements made by the Enrolling 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 Enrolling Group or by a Subscriber to void the Policy after it has been in force for a period of two years. Once the Policy has been in effect for two years it may not be terminated except for non-payment of Premiums.

A statement made to effectuate coverage may not be used to avoid the coverage or reduce Benefits under the Policy unless:
The statement is contained in a written instrument signed by the Enrolling Group or Subscriber, and
A copy of the statement is given to the Enrolling Group or Subscriber.

Statement of Age by Covered Person
A misstatement of age made by the Covered Person under the Policy will cause a Premium adjustment to correspond with the Covered Person's true age. Additionally, if Benefits are affected by a change in age, Benefits will be corrected accordingly (in which case, the Premium adjustment will take the age correction into account).

Incentives to Providers
We pay Network providers through various types of contractual arrangements, some of which 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.

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 contact 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.

Incentives to You
Sometimes we may offer coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but we recommend that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. Contact us if you have any questions.

Rebates and Other Payments
We may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. We do not pass these rebates on to you, nor are they taken into account in determining your Copayments.

Interpretation of Benefits
We have sole and exclusive discretion 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 and any Riders and Amendments.
• Make factual determinations related to the Policy and its Benefits.

We may delegate this discretionary authority to other persons or entities who provide services in regard to the administration of the Policy.

In certain circumstances, for purposes of overall cost savings or efficiency, we may, in our sole discretion, offer Benefits for services that would otherwise not be Covered Health 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.

Administrative Services
We may, in our sole discretion, arrange for various persons or entities to provide administrative services in regard to the Policy, 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 in our sole discretion. 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 reserve the right, in our sole discretion and without your approval, to change, interpret, modify, withdraw or add Benefits or terminate 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 hereby 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. All of the following conditions apply:

• Amendments to the Policy are effective 31 days after we send written notice to the Enrolling Group.
• Riders are effective on the date we specify.
• 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.

Clerical Error
If a clerical error or other mistake occurs, that error will not deprive you of Benefits under the Policy, nor will it create a right to Benefits. If the Enrolling Group makes a clerical error (including, but not limited to, sending us inaccurate information regarding your enrollment for coverage or the termination of your coverage under the Policy) we will not make retroactive adjustments beyond a 60-day time period.

Information and Records
At times we may need additional information from you. You agree to furnish us with all information and proofs that we may reasonably require regarding any matters pertaining to the Policy. If you do not provide this information when we request it we may delay or deny payment of your Benefits.

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 any and all records concerning health care services which are necessary to implement and administer the terms of the Policy, for appropriate medical review or quality assessment, or as we are required to do 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.

For complete listings of your medical records or billing statements we recommend that you 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, we will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Our designees have the same rights to this information as we have.

**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.

**Workers' Compensation not 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 Member 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.

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

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment we made exceeded the Benefits under the Policy.

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, the Covered Person agrees to help us get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits for the Covered Person that are payable under the Policy. We may also reduce future Benefits for the Covered Person under any other group benefits plan that we administer for the Enrolling Group. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

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 after the date written proof of loss is required to be furnished or you lose any rights to bring such an action against us.

You cannot bring any legal action against us for any other reason unless you first complete all the steps in the complaint process described in (Section 6: Questions, Complaints, Appeals). After completing that process, if you want to bring a legal action against us you must do so within three years of the date we notified you of our final decision on your complaint or you lose any rights to bring such an action against us.

Entire Policy
The Policy issued to the Enrolling Group, including this Certificate, the Enrolling Group's application, Amendments, and Riders constitutes the entire Policy.
Section 10: Glossary of Defined Terms

This section:
• Defines the terms used throughout this Certificate.
• Is not intended to describe Benefits.

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

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

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

Benefits - your right to payment for Covered Health Services that are available under the Policy. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of the Policy, including this Certificate and any attached Riders and Amendments.

Bereavement Counseling - counseling provided to the Immediate Family or Family Caregiver of the Covered Person after the Covered Person’s death to help the Immediate Family or Family Caregiver cope with the death of the insured.

Body Mass Index - 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.

Chlamydia Screening Test - any laboratory test that both:

• Specifically tests for infection by one or more agents of chlamydia trachomatis.
• Is approved for this purpose by the federal Food and Drug Administration.

Clinical Trial - the following treatments when approved by one of the National Institutes of Health, an NIH cooperative group or an NIH center, the FDA in the form of an investigational new drug application, the federal Department of Veterans Affairs, or an institutional review board of a Maryland institution which has a multiple project assurance contract approved by the Office of Protection From Research Risks of the National Institutes of Health:

• Treatment provided in a Phase I, Phase II, Phase III or Phase IV clinical trial for a life-threatening condition.
• Treatment provided or studies conducted in a Phase I, Phase II, Phase III or Phase IV clinical trial for prevention, early detection and treatment studies on cancer.

Chiropractic Services - care and services provided by or under the direction and supervision of a licensed chiropractor. This would include all services that are covered under the chiropractor’s scope of practice.
Congenital Anomaly - a physical developmental defect that is present at birth, and is identified within the first twelve months of birth.

Copayment - the charge you are required to pay for certain Covered Health Services. A Copayment may be either a set dollar amount or a percentage of Eligible Expenses.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by us.

Covered Health Service(s) - those health services provided for the purpose of preventing, diagnosing or treating a Sickness, Injury, mental illness, substance abuse, or their symptoms.

A Covered Health Service is a Medically Necessary health care service or supply described in (Section 1: What's Covered--Benefits) as a Covered Health Service, which is not excluded under (Section 2: What's Not Covered--Exclusions).

Covered Person - either the Subscriber or an Enrolled Dependent, but this term applies only while the person is enrolled under the Policy. References to "you" and "your" throughout this Certificate are references to a Covered Person.

Custodial Care - services that:

- Are non-health related services, such as assistance in activities of daily living (including but not limited to feeding, dressing, bathing, transferring and ambulating); or
- Are health-related services which do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the service is not changing; or
- Do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Dependent - the Subscriber's legal spouse or an unmarried dependent child of the Subscriber or the Subscriber's spouse. All references to the spouse of a Subscriber shall include a Domestic Partner. The term child includes any of the following:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child, including a grandchild of the Subscriber or the Subscriber's spouse, for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.
- A child under testamentary or court appointed guardianship to the Subscriber.

To be eligible for coverage under the Policy, a Dependent must reside within the Service Area or reside with the Subscriber who works within the Service Area.

The definition of Dependent is subject to the following conditions and limitations:

- A Dependent includes any unmarried dependent child under 26 years of age.
- A Dependent includes an unmarried dependent child who is 26 years of age or older, but less than 26 years of age only if you furnish evidence upon our request, satisfactory to us, of all the following conditions:
  - The child must not be regularly employed on a full-time basis.
— The child must be a Full-time Student.
— The child must be primarily dependent upon the Subscriber for support and maintenance.

- A Dependent includes an unmarried dependent child who is 26 years of age or older and who is incapable of self-support by reason of mental or physical incapacity only if:
  — The child becomes incapacitated while enrolled for coverage under the group Policy, or
  — The child was enrolled as a dependent under a prior Policy that was replaced by the group Policy.

The mental or physical incapacitation must have occurred prior to the child's 26th birthday. The child must reside with the Subscriber and must be primarily dependent upon the Subscriber for support and maintenance. Proof of the child's dependency and incapacity must be provided to us upon our request.

The Subscriber must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy these conditions.

A Dependent also includes a child for whom health care coverage is required through a 'Qualified Medical Child Support Order' or other court or administrative order, even if the child does not reside within the Service Area. The Enrolling Group is 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 Dependent coverage and include the child in that coverage 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 terminate health insurance coverage for the child unless written evidence of any of the following 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 Dependents' coverage for all of its employees.
  — 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: a) was born out of wedlock; b) is not claimed as dependent on the Subscriber's federal income tax return; c) does not reside with the Subscriber, or (d) is receiving benefits or is eligible to receive benefits under the Maryland Medical Assistance Program.

**Designated Facility** - a facility that has entered into an agreement on behalf of the facility and its affiliated staff with us or with an organization contracting on our behalf, to render Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within your

To continue reading, go to right column on this page.  
To continue reading, go to left column on next page.
geographic area. The fact that a Hospital is a Network Hospital does not mean that it is a Designated Facility.

**Domestic Partner** - a person of the opposite or same sex with whom the Subscriber has established a Domestic Partnership.

**Domestic Partnership** - a relationship between a Subscriber and one other person of the opposite or same sex. All of the following requirements apply to both persons:

- They must not be related by blood or a degree of closeness that would prohibit marriage in the law of the state in which they reside.
- They must not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
- They must share the same permanent residence and the common necessities of life.
- They must be at least 18 years of age.
- They must be mentally competent to consent to contract.
- They must be financially interdependent and they have furnished documents to support at least two of the following conditions of such financial interdependence:
  - They have a single dedicated relationship of at least six months duration.
  - They have joint ownership of a residence.
  - They have at least two of the following:
    - A joint ownership of an automobile.
    - A joint checking, bank or investment account.
    - A joint credit account.
    - A lease for a residence identifying both partners as tenants.
- A will and/or life insurance policies which designates the other as primary beneficiary.

**Durable Medical Equipment** - the least costly type of medical apparatus that is all of the following:

- Ordered or prescribed by a Physician as essential in the treatment of the Sickness, Injury or their symptoms.
- Can withstand repeated use (other than consumable supplies).
- Not useful generally to an individual in the absence of a Sickness, Injury or their symptoms.
- Primarily designated for medical purposes (not personal comfort or convenience).
- Primarily for use in the home.

**Eligible Expenses** - for Covered Health Services, incurred while the Policy is in effect, Eligible Expenses are determined by us as stated below:

Eligible Expenses are based on either of the following:

- When Covered Health Services are received from Network providers, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from non-Network providers as a result of an Emergency or as otherwise arranged by us, the applicable payment for Eligible Expenses is set forth under Section 19-710.1 of the Maryland Health General Article.

**Eligible Person** - an employee of the Enrolling Group or other person whose connection with the Enrolling Group meets the eligibility requirements specified in both the application and the Policy. An Eligible Person must reside and/or work within the Service Area.
**Emergency** - a condition requiring immediate treatment of a sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that in the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in:

- Placing the Covered Person's health in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

**Emergency Health Services** - health care services and supplies necessary for the treatment of an Emergency.

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

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

**Experimental or Investigational Services** - medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies 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 or in the medical literature as appropriate for the proposed use.
- Subject to review and approval by the institutional review board of the treating facility for the proposed use.
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

If you have a life-threatening Sickness or condition (one which is likely to cause death within one year of the request for treatment) we may, in our discretion, determine that an Experimental or Investigational Service meets the definition of a Covered Health Service for that Sickness or condition. For this to take place, we must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

**NOTE:** This definition does not include Covered Health Services in a Clinical Trial.

**Family Caregiver** - a relative by blood, marriage, or adoption who lives with or is the primary caregiver of the Terminally Ill insured.

**Family Counseling** - counseling given 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 person's death.

**Full-time Student** - a person who is enrolled in and attending, full-time, a recognized course of study or training at one of the following:

- An accredited high school.
- An accredited college or university.
- A licensed vocational school, technical school, beautician school automotive school or similar training school.
Full-time Student status is determined in accordance with the standards set forth by the educational institution. You are no longer a Full-time Student at the end of the calendar month during which you graduate or otherwise cease to be enrolled and in attendance at the institution on a full-time basis.

You continue to be a Full-time Student during periods of regular vacation established by the institution. If you do not continue as a Full-time Student immediately following the period of vacation, the Full-time Student designation will end as described above.

**Habilitation Services** - services, including occupational therapy, physical therapy, and speech therapy, for the treatment of a child with a congenital or genetic birth defect to enhance the child's ability to function. For purposes of Habilitation Services, a congenital or genetic birth defect means a defect existing at or from birth, including a hereditary defect. A congenital or genetic birth defect includes, but is not limited to (a) autism or an autism spectrum disorder, and (b) cerebral palsy.

**Hearing Aid** - a device of a design and circuitry to optimize audibility and listening skills in the environment commonly experienced by children that is nondisposable.

**Home Health Agency** - a program or organization authorized by law to provide health care services in the home.

**Hospice Care Program** - a coordinated, interdisciplinary program of hospice care services for meeting the special physical, psychological, spiritual, and social needs of Terminally Ill individuals and their families, by providing palliative and supportive medical, nursing, and other health services through home or inpatient care during the illness and bereavement to:

- Individuals who have no reasonable prospect of cure as estimated by a Physician; and
- The Immediate Families or Family Caregivers of those individuals.

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

- Is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- Has 24 hour nursing services.

A Hospital is not primarily a place for rest, custodial care or care of the aged and is not a nursing home, convalescent home or similar institution.

**Human Papillomavirus Screening Test** - any laboratory test that both:

- Specifically detects for infection by one or more agents of the human papillomavirus.
- Is approved for this purpose by the federal Food and Drug Administration.

**Immediate Family** - the spouse, parents, siblings, grandparents, and children of a Terminally Ill person.

**Inherited Metabolic Disease** - a disease caused by an inherited abnormality of body chemistry, including a disease for which the state screens newborn babies.

**Initial Enrollment Period** - the initial period of time, as we agree with the Enrolling Group, during which Eligible Persons may enroll themselves and their Dependents under the Policy.
**Injury** - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

**Inpatient Rehabilitation Facility** - a Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

**Inpatient Stay** - an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility or Treatment Facility.

**Low Protein Modified Food Product** - a food product that is both:

- Specially formulated to have less than 1 gram of protein per serving.
- 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** - a food that is both:

- Intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation.
- Formulated to be consumed or administered enterally under the direction of a Physician.

**Medically Necessary** - health care services which are reasonably necessary and in the exercise of good medical practice in accordance with professional standards accepted and commonly available in the United States for treatment of Sickness or Injury, as determined by us. The services must meet all of the following criteria.

- Be appropriate and necessary for the symptom(s), diagnosis, or treatment of the condition, Sickness or Injury.
- Be provided for the diagnosis or direct care or treatment of the condition, Sickness or Injury.
- Not be provided for convenience.
- Be performed or provided in the least costly setting or manner appropriate to diagnose or treat the Injury or Sickness.

We use our utilization management plan/coordination of care plan, as well as other nationally recognized guidelines when determining medical necessity.

**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.

**Morbid Obesity** - a Body Mass Index that is: (1) greater than 40 kilograms per meter squared; or (2) equal to or greater than 35 kilograms per meter squared with a co-morbid medical condition including hypertension, a cardiopulmonary condition, sleep apnea, or diabetes.

**Multiple Risk Factors** - having a prior history of a sexually transmitted disease, new or multiple sex partners, inconsistent use of barrier contraceptives, or cervical ectopy.

**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. 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 Services, but not all Covered Health 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 Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

**Open Enrollment Period** - a period of time that follows the Initial Enrollment Period during which Eligible Persons may enroll themselves and Dependents under the Policy. We and the Enrolling Group will agree upon the period of time that is the Open Enrollment Period.

**Out-of-Pocket Maximum** - the maximum amount of Copayments you pay every calendar year. Once you reach the Out-of-Pocket Maximum, Benefits for those Covered Health Services that apply to the Out-of-Pocket Maximum are payable at 100% of Eligible Expenses during the rest of that calendar year. Copayments for some Covered Health Services will never apply to the Out-of-Pocket Maximum, as specified in (Section 1: What's Covered--Benefits) and those Benefits will never be payable at 100% even when the Out-of-Pocket Maximum is reached.

The following costs will never apply to the Out-of-Pocket Maximum:

- Any charges for non-Covered Health Services.
- Copayments for Covered Health Services available through any Outpatient Prescription Drug Rider.
- Any Copayments for Covered Health Services in (Section 1: What's Covered--Benefits) that do not apply to the Out-of-Pocket Maximum.

Even when the Out-of-Pocket Maximum has been reached, you will still be required to pay:

- Any charges for non-Covered Health Services.
- Copayments for Covered Health Services available through any Outpatient Prescription Drug Rider.
- Copayments for Covered Health Services in (Section 1: What's Covered--Benefits) that are subject to Copayments that do not apply to the Out-of-Pocket Maximum.

**Partial Hospitalization** - the provision of medically directed intensive or intermediate short-term treatment that is all of the following:

- To a Covered Person.
- In a licensed or certified facility or program.
- For mental illness, emotional disorders, drug abuse, or alcohol abuse.
- For a period of less than 24 hours but more than 4 hours in a day.

**Physician** - any Doctor of Medicine, "M.D.", or Doctor of Osteopathy, "D.O.", who is properly licensed and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, optometrist, dietician or nutritionist, or certified nurse-midwife or other provider who acts within the scope of his or her license, except a chiropractor, will be considered on the same basis as a Physician. All services provided by a chiropractor that is acting within the scope of his or her license are described separately under Chiropractic Services above. 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 Enrolling Group, that includes all of the following:

- The group Policy.
- This Certificate.
- The Enrolling Group's application.
- Amendments.
- Riders.

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

**Policy Charge** - the sum of the Premiums for all Subscribers and Enrolled Dependents enrolled under the group 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.

**Primary Care Physician** - a Network Physician that you select to be responsible for providing or coordinating all Covered Health Services. A Primary Care Physician has entered into an agreement with us to provide primary care health services to Covered Persons. The majority of his or her practice generally includes pediatrics, internal medicine, obstetrics/gynecology, or family or general practice.

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

- Provided to a child or an adult with a mental illness who is experiencing or is at risk of a 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** - provides intermediate services to patients with long-standing multiple disturbances in behavior, age appropriate adaptive functioning, social problem-solving, and psychological functioning. The severity and complexity of disturbances are such that there is a low probability that the patient's treatment could be managed in a normal home environment or alternative living situation (group home, foster placement, legal system). Because the problems are long-standing in nature, they do not represent an acute deterioration from baseline. Because there is no evidence of imminent risk at the time of appropriate admission, residential placement is always considered an elective, planned admission.

**Respite Care** - temporary care provided to the Terminally Ill person to relieve the Family Caregiver from the daily care of the insured.

**Rider** - any attached written description of additional Covered Health Services not described in this Certificate. Covered Health Services provided by a Rider may be subject to payment of additional Premiums. 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 Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

**Service Area** - the geographic area we serve and that 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.

**Sickness** - physical illness, disease or Pregnancy. The term Sickness as used in this Certificate does not include mental illness or substance abuse, regardless of the cause or origin of the mental illness or substance abuse.

**Skilled Nursing Facility** - a Hospital or nursing facility that is licensed and operated as required by law.

**Specialist Physician** - 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.

**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 Enrolling Group.

**Treatment Facility** - a residential or non-residential facility or program licensed, certified or otherwise authorized pursuant to the law of jurisdiction for treatment of mental illness, alcohol and drug abuse.

**Terminally Ill** - a medical prognosis given by a Physician that a Covered Person's life expectancy is 6 months or less.

**Total Disability** - with respect to a Subscriber, a disability due to Injury, Sickness or mental illness and substance abuse that requires the regular care and attendance of a Physician and, in our opinion renders the Subscriber unable to perform the duties of his or her regular occupation.

Total Disability, with respect to a Dependent, is a disability due to Injury or Sickness that requires the regular care and attendance of a Physician, and renders the Dependent unable to engage in most of the normal activities of a person of like age and gender.

**Unproven Services** - services that are not consistent with conclusions of prevailing medical research which demonstrate that the health service has a beneficial effect on health outcomes and that are not based on trials that meet either of the following designs.

- 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. (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.)

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

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, in our discretion, determine that an Unproven Service meets the
definition of a Covered Health Service for that Sickness or condition. For this to take place, we must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

**NOTE:** This definition does not include Covered Health Services in a Clinical Trial.

**Urgent Care Center** - a facility, other than a Hospital, that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

**Urgent Medical Condition** - 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 behalf of a carrier, 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.
  - The Covered Person remaining seriously mentally ill with symptoms that cause the member to be a danger to self or others.

- A medical condition, including a physical condition, a mental health condition, or a dental condition, where the absence of medical attention within 72 hours in the opinion of a health care provider with knowledge of the Covered Person's medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the coverage decision.

- End of Certificate -
Riders, Amendments, Notices

Amino Acid Based Elemental Formula Amendment

Dependent Amendment

Outpatient Prescription Drug Rider

Dependent, Domestic Partner, Domestic Partnership Definitions Amendment

Important Notices under the Patient Protection and Affordable Care Act (PPACA)

Outpatient Diagnostic Services Amendment

Changes in Federal Law that Impact Benefits

Patient Protection and Affordable Care Act (PPACA) Amendment

Women's Health and Cancer Rights Act of 1998

Questions, Complaints, Appeals Amendment

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Prosthetic Device and Breast Cancer Screening Amendment

Claims and Appeal Notice

Hearing Aid, Mental Health Parity and Special Enrollment Amendment

HIPAA Notice
COBRA Notice

Health Plan Notices of Privacy Practices

ERISA
Amino Acid Based Elemental Formula Amendment

As described in this Amendment, the Policy is modified to provide coverage for Amino Acid Based Elemental Formula.
The following provision is added to the Certificate of Coverage, (Section 1: What's Covered--Benefits):

**Benefit Information**

<table>
<thead>
<tr>
<th>Description of Covered Health Service</th>
<th>Your Copayment Amount</th>
<th>Does Copayment Help Meet Out-of-Pocket Maximum?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amino Acid Based Elemental Formula</td>
<td>No Copayment</td>
<td>No</td>
</tr>
</tbody>
</table>

Coverage will be provided for Amino Acid-Based Elemental Formula, regardless of delivery method, for the diagnosis and treatment of:

a. Immunglobulin E and non-Immunoglobulin E mediated allergies to multiple food proteins;

b. Severe Food protein induced Enterocolitis syndrome;

c. Eosinophilic Disorders (as evidenced by results of a biopsy); and
d. Impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.
Section 2: What's Not Covered--Exclusions

The exclusion for Nutrition in the Certificate under (Section 2: What's Not Covered--Exclusions), item 4 is replaced with the following:

4. Except as described above under Enteral Formulas and Amino Acid Based Elemental Formula in Section 1: What's Covered--Benefits, enteral feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk.

OPTIMUM CHOICE, INC.

James P. Cronin, Jr. CEO
As described in this Amendment, the Policy is modified to provide revised definitions of Dependent, Domestic Partner and Domestic Partnership. Additionally, in this Amendment, the Policy is amended to provide revisions to the provisions for "Adding New Dependents".

Because this Amendment 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 10: Glossary of Defined Terms) and in this Amendment below.
Section 4: When Coverage Begins

We provide Provisions for Adding New Dependents as described in this Amendment to the Policy. Provisions described in this Amendment replace the Provisions stated in the Certificate of Coverage, (Section 4: When Coverage Begins), Adding New Dependents.

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 or grandchild of the Subscriber or the Subscriber's spouse is covered automatically from the moment of birth for at least 31 days provided at least one family member other than the Subscriber is covered under the Policy at the time of the birth.
- The newly adopted child or newly adopted grandchild of the Subscriber or the Subscriber's spouse is covered automatically from the date of adoption for at least 31 days provided at least one family member other than the Subscriber is covered under the Policy on the date of adoption or placement for adoption.
"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.

- The child in the custody of the Subscriber or the Subscriber's spouse as a result of a guardianship, other than a temporary guardianship of less than twelve months duration, granted by a court or testamentary appointment is covered automatically from the date of such appointment for at least 31 days provided at least one family member other than the Subscriber is covered under the Policy on the date of appointment.

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

- 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.

- The new spouse of the Subscriber will have effected coverage on the first day of the first month following approval of the enrollment application, provided written enrollment is made within 31 days from the date of such legal marriage.

- A newly eligible, Dependent grandchild of the Subscriber or the Subscriber's spouse who is
not a newborn or adopted will have effected coverage on the first day of the first month following approval of the enrollment application, provided written enrollment is made within 31 days from the date first eligible.

- The new stepchild of the Subscriber will have effected coverage on the first day of the first month following approval of the enrollment application, provided written enrollment is made within 31 days from the date of the legal marriage, between the Subscriber and the child's parent.

- The new Domestic Partner of the Subscriber will have effected coverage on the first day of the first month following approval of the enrollment application, provided written enrollment is made within 31 days from the date of such union, in accordance with the requirements of "Domestic Partner" and "Domestic Partnership" as found in this certificate of coverage, Section 10: Glossary of Defined Terms
Section 10: Glossary of Defined Terms

We provide Benefits for Dependents as defined in this Amendment to the Policy. The definition of Dependent defined in this Amendment replaces the definition of Dependent stated in the Certificate of Coverage, (Section 10: Glossary of Defined Terms).

Dependent - the Subscriber's legal spouse or an unmarried child dependent of the Subscriber. All references to the child dependent of a Subscriber shall include the child dependent of the Domestic Partner or the Subscriber's spouse. All references to the spouse of a Subscriber shall include a Domestic Partner. The term child dependent includes any of the following:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A grandchild.
- 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.

The definition of Dependent is subject to the following conditions and limitations:

- A Dependent includes any unmarried child dependent under 25 years of age.
- A Dependent includes an unmarried child dependent who is between 25 and 26 years of age only if the following are true:
  - The child is not regularly employed on a full-time basis and
  - The child receives over half of his or her support from the Subscriber for support and maintenance.
- A Dependent includes an unmarried child dependent of any age who is or becomes disabled and dependent upon the Subscriber.

The Subscriber must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy these conditions.

A Dependent also includes 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:
Optimum Choice, Inc.

- 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 terminate 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 in the Service area; or
  - Is receiving benefits or is eligible to receive benefits under the Maryland Medical Assistance Program.

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

We provide Benefits for Domestic Partner as defined in this Amendment to the Policy. The definition of Domestic Partner defined in this Amendment replaces the definition of Domestic Partner stated in the Certificate of Coverage, (Section 10: Glossary of Defined Terms).

**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 degree 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.
The definition of Domestic Partnership in the Certificate under (Section 10: Glossary of Defined Terms) is deleted in its entirety.

The definition of Full-Time Student in the Certificate under (Section 10: Glossary of Defined Terms) is deleted in its entirety.
We provide Benefits for Outpatient Diagnostic Services as described in this Amendment to the Policy. Benefits described in this Amendment replace the Benefits stated in the Certificate of Coverage, (Section 1: What's Covered—Benefits), Outpatient Diagnostic Services.

<table>
<thead>
<tr>
<th>Description of Covered Health Service</th>
<th>Your Copayment Amount</th>
<th>Does Copayment Help Meet Out-of-Pocket Maximum?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lab and radiology/X-ray.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mammography.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefits for bone mass measurement (a radiologic or radioisotopic procedure, or other scientifically proven technology) for the prevention, diagnosis, and treatment of osteoporosis when the bone mass measurement is requested by a Physician. Benefits for bone mass measurement include, but are not limited to, those provided when:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>— You are at risk for osteoporosis.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>— You have specific sign suggestive of spinal osteoporosis, including roentgenographic osteopenia or roentgenographic</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*For preventive diagnostic lab services:*

- No Copayment  No
<table>
<thead>
<tr>
<th>Description of Covered Health Service</th>
<th>Your Copayment Amount</th>
<th>Does Copayment Help Meet Out-of-Pocket Maximum?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evidence suggestive of collapse, wedging, or ballooning of one or more thoracic or lumbar vertebral bodies, who is a candidate for therapeutic intervention or for an extensive diagnostic evaluation for metabolic bone disease.</td>
<td>% Copayments are based on a percent of Eligible Expenses</td>
<td></td>
</tr>
<tr>
<td>---</td>
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</tr>
<tr>
<td>— You are receiving long-term glucocorticoid (steroid) therapy.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>— You have hyperparathyroidism.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>— You are being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Benefits under this section 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 *Professional Fees for Surgical and Medical Services*.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.

This section does not include Benefits for CT scans, PET scans, MRIs, or nuclear medicine, which are described below.
<table>
<thead>
<tr>
<th>Description of Covered Health Service</th>
<th>Your Copayment Amount</th>
<th>Does Copayment Help Meet Out-of-Pocket Maximum?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>diagnostic lab services:</strong></td>
<td>% Copayments are based on a percent of Eligible Expenses</td>
<td></td>
</tr>
<tr>
<td>$0 at an Alternate Facility;</td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>$30 at a Hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>For Sickness and Injury-related</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>diagnostic radiology/X-ray services:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$30 at an Alternate Facility;</td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>$30 at a Hospital</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

OPTIMUM CHOICE, INC.

James P. Cronin, Jr. CEO
Patient Protection and Affordable Care Act (PPACA) Amendment

Optimum Choice, Inc.

As described in this Amendment, the contract is modified as stated below.

Because this Amendment reflects changes in requirements of Federal law, to the extent it may conflict with any Amendment issued to you previously, the provisions of this Amendment will govern.

Children's Coverage to Age 26

The provisions of the contract that define a "child" or that describes the eligibility requirements or causes of termination of a child's coverage are revised as follows to comply with 45 CFR Parts 144, 146 and 147.

Eligibility

Any provision of the contract that indicates that a child's eligibility for coverage is based on any factor other than the relationship between the child and an individual covered under the contract is deleted. Any requirement that the child be financially dependent on an individual covered under the contract, that the child share a residence with an individual covered under the contract, that the child meet certain student status requirements, that the child be unmarried, that the child not be eligible for other coverage, or that the child not be employed, is deleted.

Termination

Any provision of the contract that indicates that a child's coverage will terminate when the child marries, ceases to be financially dependent on an individual covered under the contract, ceases to share a residence with an individual covered under the contract, ceases to be a full-time or part-time student, is eligible for other coverage, becomes employed full-time or part-time, or reaches the child's 25th birthday is deleted.

The contract is revised to provide that coverage of a child will terminate on the date the child reaches his or her 26th birthday. The limiting age will not apply to a child, who at the time of reaching the limiting age, is incapable of self-support because of mental or physical incapacity that started before the child attained the limiting age, provided the incapacitated child is unmarried and dependent on an individual covered under the contract. Coverage of the incapacitated child will continue for as long as the child remains incapable of self-support because of a mental or physical incapacity, unmarried, and dependent on an individual covered under the contract.

Definition of Child

Any provision of the contract that defines or describes which children can be covered under the contract is revised to include a child who has not attained the child's 26th birthday irrespective of the child's:
Optimum Choice, Inc.

- Financial dependency on an individual covered under the contract;
- Marital status;
- Residency with an individual covered under the contract;
- Student status;
- Employment;
- Eligibility for other coverage; or
- Satisfaction of any combination of the above factors.

Transition for Children Previously Denied Enrollment or Who Terminated Coverage Due to Attaining Limiting Age

The contract is amended to provide coverage from the first day of the first plan year occurring on or after September 23, 2010, if the child meets both of the following:

- The child was terminated from coverage previously due to failure to satisfy the child definition of the contract or the child was prohibited from enrolling under the contract due to failure to meet the child definition in the contract; and
- The child enrolls during the first thirty (30) days of the first plan year occurring on or after September 23, 2010.

Definitions

The following definitions have the following meanings in this amendment rider:

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

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

**Emergency Medical Condition** - means 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 individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

**Essential Health Benefits** - has the meaning found in section 1302(b) of the Patient Protection and Affordable Care Act and as further defined by the Secretary of the United States Department of Health and Human Services and includes ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

**Non-Participating Provider** - means a health care practitioner or health care facility that has not contracted directly with Optimum Choice, Inc. or an entity contracting on behalf of Optimum Choice,
Optimum Choice, Inc. to provide health care services to Optimum Choice, Inc.'s enrollees.

**Participating Provider** - means a health care practitioner or health care facility that has contracted directly with Optimum Choice, Inc. or an entity contracting on behalf of Optimum Choice, Inc. to provide health care services to Optimum Choice, Inc.'s enrollees.

**Lifetime Dollar Limits (Maximum Policy Benefit)**

Any lifetime dollar limit on any Essential Health Benefits in the group contract is deleted.

The contract is amended to provide that if an individual's coverage under the contract had terminated due to reaching a lifetime dollar limit, the individual may enroll during the first thirty (30) days of a plan year that begins on or after September 23, 2010, and coverage will begin on the first day of the plan year that begins on or after September 23, 2010.

**Annual Dollar Limits**

Any annual dollar limit on any Essential Health Benefits in the contract is amended to be the greater of (1) the annual dollar limit permitted under 45 CFR 147.126; and (2) the annual dollar limit described in the contract.

**Rescissions**

Any provision of the contract that describes the right of Optimum Choice, Inc. to rescind or void the contract or to rescind the coverage of an individual under the contract is amended to permit Optimum Choice, Inc. to rescind or void the entire group contract or the coverage of an individual only if (1) the individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud; or (2) the individual (or a person seeking coverage on behalf of the individual) makes an intentional misrepresentation of material fact.

Any provision of the group contract that describes notice of rescission of coverage and that provides less than thirty (30) days advance written notice of rescission is amended to provide thirty (30) days advance written notice of any rescission of coverage.

**Preventive Services**

In addition to any other preventive benefits described in the group contract, Optimum Choice, Inc. shall cover the following preventive services and shall not impose any cost-sharing requirements, such as deductibles, copayment amounts or coinsurance amounts to any covered individual receiving any of the following benefits for services received from Participating Providers:

- Evidenced-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, except that the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention of breast cancer shall be considered the most current other than those issued in or around November 2009;
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the
Optimum Choice, Inc.

comprehensive guidelines supported by the Health Resources and Services Administration; and

- With respect to women, such additional preventive care and screenings, not described in the first bullet point above, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Optimum Choice, Inc. shall update new recommendations to the preventive benefits listed above at the schedule established by the Secretary of Health and Human Services.

Prohibition on Pre-Existing Conditions for Children

The following provisions of the group contract shall not apply to any child who is under the age of nineteen (19):

- Any provision that describes a pre-existing condition exclusion or limitation;
- Any provision that indicates that a pre-existing condition exclusion or limitation is applicable;
- Any provision that indicates that benefits are contingent on an injury occurring or a sickness first manifesting itself while the child is covered under the group contract; and
- Any provision of the group contract that describes possible denial or rejection of coverage due to underwriting.

Choice of Provider

Any provision of the group contract that indicates that an individual is required to designate or provide for the designation of a primary care provider is amended to permit the individual to select any participating primary care provider who is available to accept the individual.

Any provision of the group contract that indicates that a primary care provider is required to be designated for a child, is amended to permit the designation of any participating physician (allopathic or osteopathic) who specializes in pediatrics as the child's primary care provider, if the provider is available to accept the child.

Any provision of the group contract that requires a woman to receive a referral or authorization from the primary care provider before receiving obstetrical or gynecological care is deleted. The group contract is also amended to provide that the obstetrical and gynecological care received from a participating provider who specializes in obstetrics or gynecological care is deleted. The group contract is also amended to provide that the obstetrical and gynecological care received from a participating provider who specializes in obstetrics or gynecological care without the referral or authorization from the primary care provider includes the ordering of related obstetrical and gynecological items and services that are covered under the group contract.

Emergency Services

Any provision of the group contract that provides benefits with respect to services in an emergency department of a hospital is amended to provide Emergency Services:

- Without the need for any prior authorization determination, even if the Emergency Services are provided by a Non-Participating Provider;
- Without regard to whether the health care provider furnishing the Emergency Services is a Participating Provider with respect to the services; and
- If the Emergency Services are provided by a Non-Participating Provider, 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.

Cost-Sharing Requirements for
Emergency Services
If any copayment amount or coinsurance percentage described in the
group contract for Emergency Services is different for a service

Effective Date of this Amendment: January 1, 2013

Optimum Choice, Inc.

OPTIMUM CHOICE, INC.

James P. Cronin, Jr. CEO
Questions, Complaints, Appeals Amendment

Because this Amendment reflects changes in requirements of State law, to the extent it may conflict with any Amendment issued to you previously, the provisions of this Amendment will govern.

As described in this Amendment, the Policy is modified by replacing (Section 6: Questions, Complaints, Appeals) of the Certificate of Coverage with the provision below.

Section 6: Questions, Complaints, Appeals

This section provides you with information to help you with the following:

- You have a question or concern about Covered Health Services or your Benefits.
- You have a complaint.
- We notify you that we will not be paying a claim because we have determined that a service or supply is excluded under the Policy.

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

What to Do if You Have a Question
Contact Customer Service at the telephone number shown on your ID card. Customer Service representatives are available to take your call during regular business hours, Monday through Friday.

What to Do if You Have a Complaint
Contact Customer Service at the telephone number shown on your ID card. Customer Service 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 Customer Service representative can provide you with the appropriate address.
If the Customer Service representative cannot resolve the issue to your satisfaction 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 utilization review determination that a proposed or delivered Covered Health 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 care service; or our denial of a request by a Covered Person for an alternative standard or a waiver of a standard for a bona-fide wellness program, if applicable under the Policy, as required under Maryland insurance law.
- "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, or the Covered Person remaining seriously mentally ill with symptoms that cause the Covered Person to be in danger to self or others.
- "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 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 a 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 requirement 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 on your behalf, file an adverse decision complaint with the Insurance Commissioner, unless the adverse decision involves an urgent condition 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 on your behalf, 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 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 Services whereby the preauthorization or approval for such Covered Health 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 the 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 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, 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 appropriate information in the bulleted items under Adverse Decision above. This notice will also include a statement that the Health Advocacy Unit is available to assist you or your representative in filing a complaint with the Insurance Commissioner.

- 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 bullets describe 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 for which a delay would result in loss of life, serious impairment to a bodily function, serious dysfunction of a bodily organ or the Covered Person remaining seriously mentally ill with symptoms that cause the Covered Person to be in danger to self or others.

**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.

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 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 appropriate information specified for the Notice of Adverse Decision above and will include that the Health Advocacy Unit is available to assist you or your representative in filing a compliant with the Insurance Commissioner.

**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:

Optimum Choice, Inc.
4 Taft Court
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 working day after the Insurance Commissioner has given verbal notification of the final decision.
- For an adverse decision complaint involving a pending health service, the Insurance Commissioner's final decision will be made within 45 days after the adverse decision complaint is filed.
- For an adverse decision complaint involving a retrospective denial of health services already provided, the Insurance Commissioner's final decision will be made within 45 days after the adverse decision complaint is filed.

Except for emergency cases, the time periods above 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

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**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.

"Your representative" means an individual who has been authorized by you to file an appeal or a complaint on your behalf.

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 Customer Service at 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. 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 Insurance 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.

**Assistance From the Health Education and Advocacy Unit**
The Health Advocacy Unit can help you or your representative 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.

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

Health Education and 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

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, your representative, or the health care provider gives sufficient information and supporting documentation in the complaint that demonstrates an urgent medical condition exists.

"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; or

- A medical condition, including a physical condition, a mental health condition, or a dental condition, where the absence of medical attention within 72 hours in the opinion of a health care provider with knowledge of the Covered Person's medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the coverage decision.
As described in this Amendment, the Policy is modified to provide benefits for (i) Prosthetic Devices and (ii) guidelines for Breast Cancer Screenings.

Because this Amendment 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 10: Glossary of Defined Terms).
Section 1: What's Covered--Benefits

*Prosthetic Devices described in Section 1: (What's Covered--Benefits) is replaced with the following:*

**Benefit Information**

<table>
<thead>
<tr>
<th>Description of Covered Health Service</th>
<th>Your Copayment Amount</th>
<th>Does Copayment Help Meet Out-of-Pocket Maximum?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prosthetic Devices</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Covered Prosthetic Devices for:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>External prosthetic devices that replace a body part, limited to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Artificial face, ears and noses.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Speech aid prosthetics and tracheo-esophageal voice prosthetics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. Benefits include mastectomy bras and lymphedema stockings for the arm.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- A single hair prosthesis for loss of natural hair resulting from chemotherapy or radiation treatment for cancer.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs.

The prosthetic device must be ordered or provided by, or under the direction of a Physician. Benefits are available for repairs and
replacement, except that, (i) there are no Benefits for repairs due to misuse, malicious damage or gross neglect, and (ii) there are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices.

Except for items required by the Women's Health and Cancer Rights Act of 1998 and prosthetic legs, arms and eyes, Benefits for prosthetic devices are limited to a single purchase of each type of prosthetic device every three calendar years.

Except for items required (i) by the Women's Health and Cancer Rights Act of 1998, (ii) for a hair prosthetic device, or (iii) in whole or in part, a leg, an arm, or an eye prosthetic device, any combination of Network and Non-Network Benefits for prosthetic devices is limited to $7,500 per calendar year. This limit applies to the total amount that we will pay for the prosthetics, and does not include any Copayment responsibility you may have.

Once this Benefit limit is reached, no additional Benefits are available except for items required (i) by the Women's Health and Cancer Rights Act of 1998, (ii) for a hair prosthetic device, or (iii) in whole or in part, a leg, an arm, or an eye prosthetic device.

Benefits for a hair prosthesis are limited to a maximum of $350.

**Covered Prosthetic Devices for:**

External prosthetic devices that replace, in whole or in part, a leg, an arm, or an eye. Components of prosthetics legs, arms and eyes are also covered.
A prosthetic device replacing arms, legs, or eyes will be considered medically necessary if it satisfies the requirements of medical necessity established under the Medicare Coverage Database.

The prosthetic device must be ordered or provided by, or under the direction of a Physician. Benefits are available for repairs and replacement, except that, (i) there are no Benefits for repairs due to misuse, malicious damage or gross neglect, and (ii) there are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices.

**Mammography Services described in Section 1: (What's Covered--Benefits) is replaced with the following:**

**Benefit Information**

<table>
<thead>
<tr>
<th>Description of Covered Health Service</th>
<th>Your Copayment Amount</th>
<th>Does Copayment Help Meet Out-of-Pocket Maximum?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Cancer screenings in accordance with the latest screening guidelines issued by the American Cancer Society.</td>
<td>For Breast Cancer screenings: No Copayment</td>
<td>No</td>
</tr>
</tbody>
</table>

**Mammography testing in the Certificate of Coverage, (Section 1: What's Covered--Benefits; Outpatient Surgery, Diagnostic and Therapeutic Services) is replaced with the following:**

Breast Cancer screenings in accordance with the latest screening guidelines issued by the American Cancer Society.
Section 2: What's Not Covered--Exclusions

The exclusion in the Certificate under (Section 2: What's Not Covered--Exclusions), K. Providers, item 3. is amended by removing the following reference:

This exclusion does not apply to mammography testing.

Replacing it with the following:

This exclusion does not apply to Breast Cancer screenings in accordance with the latest screening guidelines issued by the American Cancer Society.

OPTIMUM CHOICE, INC.

James P. Cronin, Jr. CEO
Hearing Aid, Mental Health Parity and Special Enrollment Amendment

As described in this Amendment, the Policy is modified as stated below.

Because this Amendment 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 10: Glossary of Defined Terms) and in this Amendment below.
Section 1: What's Covered--Benefits

The following provision is added to (Section 1: What's Covered--Benefits):

### Benefit Information

<table>
<thead>
<tr>
<th>Description of Covered Health Service</th>
<th>Your Copayment Amount</th>
<th>Does Copayment Help Meet Out-of-Pocket Maximum?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% Copayments are based on a percent of Eligible Expenses</td>
<td></td>
</tr>
</tbody>
</table>

### 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). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

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

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

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.

| Hearing Aids | 0% | No |
### Optimum Choice, Inc.

<table>
<thead>
<tr>
<th>Description of Covered Health Service</th>
<th>Your Copayment Amount</th>
<th>Does Copayment Help Meet Out-of-Pocket Maximum?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% Copayments are based on a percent of Eligible Expenses</td>
<td></td>
</tr>
</tbody>
</table>

- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

Benefits for hearing aids are limited to $5,000 in Eligible Expenses per year. Benefits are limited to a single purchase (including repair/replacement) every three years.

---

**Mental Health and Substance Abuse Services - Inpatient and Mental Health and Substance Abuse Services - Outpatient in (Section 1: What's Covered--Benefits) are deleted and replaced with the following Covered Health Service descriptions for Mental Health Services, Neurobiological Disorders - Autism Spectrum Disorder Services and Substance Use Disorder Services.**

<table>
<thead>
<tr>
<th>Description of Covered Health Service</th>
<th>Your Copayment Amount</th>
<th>Does Copayment Help Meet Out-of-Pocket Maximum?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% Copayments are based on a percent of Eligible Expenses</td>
<td></td>
</tr>
</tbody>
</table>

### Mental Health Services

Mental Health Services include those received on an inpatient basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.

Benefits include the following services provided on either an outpatient or inpatient basis:

- Diagnostic evaluations and assessment. (Including psychological and neuropsychological testing for diagnostic purposes).

<table>
<thead>
<tr>
<th>Inpatient</th>
<th>Outpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>$300 per Inpatient Stay</td>
<td>No</td>
</tr>
</tbody>
</table>
## Description of Covered Health Service

<table>
<thead>
<tr>
<th>Description</th>
<th>Your Copayment Amount</th>
<th>Does Copayment Help Meet Out-of-Pocket Maximum?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment planning.</td>
<td>$20 per visit</td>
<td>No</td>
</tr>
<tr>
<td>Referral services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication management.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual, family, therapeutic group and provider-based management services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crisis intervention.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intermediate care.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment.
- Services at a Residential Treatment Facility.

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Designee determines coverage for all levels of care.

We encourage you to contact the Mental Health/Substance Use Disorder Designee for referrals to providers and coordination of care.

### Special Mental Health Programs and Services

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Plan.
## Neurobiological Disorders - Autism Spectrum Disorder Services

Psychiatric services for Autism Spectrum Disorders that are both of the following:

- Provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider.
- 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 psychiatric component of treatment.
for Autism Spectrum Disorders. Medical treatment of Autism Spectrum Disorders is a Covered Health Service for which Benefits are available as described under Habilitative Services in the Certificate of Coverage.

Benefits include the following services provided on either an outpatient or inpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Referral services.
- Medication management.
- Individual, family, therapeutic group, and provider-based case management services.
- Crisis intervention.

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment.
- Services at a Residential Treatment Facility.

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Designee determines
coverage for all levels of care. If an Inpatient Stay is required, it is covered on Semi-private Room basis.

We encourage you to contact the Mental Health/Substance Use Disorder Designee for referrals to providers and coordination of care.

Substance Use Disorder Services
Substance Use Disorder Services include those received on an inpatient basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.

Benefits include the following services provided on either an outpatient or inpatient basis:

- Diagnostic evaluation and assessment.
- Treatment planning.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment.
<table>
<thead>
<tr>
<th>Description of Covered Health Service</th>
<th>Your Copayment Amount</th>
<th>Does Copayment Help Meet Out-of-Pocket Maximum?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Services at a Residential Treatment Facility.</td>
<td>% Copayments are based on a percent of Eligible Expenses</td>
<td></td>
</tr>
<tr>
<td>Benefits include the following services provided on an outpatient basis:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Intensive Outpatient Treatment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Mental Health/Substance Use Disorder Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>We encourage you to contact the Mental Health/Substance Use Disorder Designee for referrals to providers and coordination of care.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Special Substance Use Disorder Programs and Services**

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Designee may become available to you as a part of your Substance Use Disorder Services Benefit. The Substance Use Disorder Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your Substance Use Disorder which may not otherwise be covered under the Policy. You must be referred to such programs through the Mental Health/Substance Use Disorder Designee, who is responsible for coordinating your care or through other pathways.
<table>
<thead>
<tr>
<th>Description of Covered Health Service</th>
<th>Your Copayment Amount</th>
<th>Does Copayment Help Meet Out-of-Pocket Maximum?</th>
</tr>
</thead>
<tbody>
<tr>
<td>as described in the program introductions. Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.</td>
<td>% Copayments are based on a percent of Eligible Expenses</td>
<td></td>
</tr>
</tbody>
</table>
Section 2: What's Not Covered--Exclusions

The exclusion for Mental Health/Substance Abuse in the Certificate under (Section 2: What's Not Covered--Exclusions) is deleted and replaced with the following:

Mental Health
Exclusions listed directly below apply to services described under Mental Health Services in (Section 1: What's Covered--Benefits).

1. Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Note: Conditions defined as Alcohol Abuse and Drug Abuse are covered regardless of whether such conditions are classified in the Diagnostic and Statistical Manual of the American Psychiatric Association. See Section 10 – Glossary of Defined Terms of Alcohol Abuse and Drug Abuse.

2. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders, and paraphilias.

3. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.

4. Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act.

5. Learning, motor skills, and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

6. Services or supplies for the diagnosis or treatment of Mental Illness that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:
   — Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
   — Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
   — Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time.

Neurobiological Disorders - Autism Spectrum Disorders
Exclusions listed directly below apply to services described under Neurobiological Disorders - Autism Spectrum Disorder Services in (Section 1: What's Covered--Benefits).

1) Mental retardation as the primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
2) Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act.

3) Services or supplies for the diagnosis or treatment of Mental Illness that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:
   — Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
   — Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
   — Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time.
   — Not clinically appropriate for the patient's Mental Illness or condition based on generally accepted standards of medical practice and benchmarks.

Substance Use Disorders
Exclusions listed directly below apply to services described under Substance Use Disorders Services in (Section 1: What's Covered--Benefits).

1) Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Note: Conditions defined as Alcohol Abuse and Drug Abuse are covered regardless of whether such conditions are classified in the Diagnostic and Statistical Manual of the American Psychiatric Association. See Section 10 – Glossary of Defined Terms of Alcohol Abuse and Drug Abuse.

2) Services or supplies for the diagnosis or treatment of alcoholism or substance use disorders that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:
   — Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
   — Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
   — Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time.
   — Not clinically appropriate for the patient's substance use disorder or condition based on generally accepted standards of medical practice and benchmark.

Exclusions for Vision and Hearing in the Certificate under (Section 2: What's Not Covered--Exclusions) are replaced with the following:

Vision and Hearing
1) Purchase cost of eye glasses or contact lenses.
2) Fitting charge for eye glasses or contact lenses.
3) Eye exercise therapy.
4) Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery.
5) Bone anchored hearing aids except when either of the following applies:
   — For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
   — For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

More than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled under the Policy.

Repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage criteria, other than for malfunctions.
Section 4: When Coverage Begins

The provision in the Certificate under (Section 4: When Coverage Begins), When to Enroll and When Coverage Begins, Special Enrollment Period is replaced with the following:

<table>
<thead>
<tr>
<th>When to Enroll</th>
<th>Who Can Enroll</th>
<th>Begin Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>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 was terminated for cause, or because premiums were not paid on a timely basis.</td>
<td>A special enrollment period applies to an Eligible Person and any Dependents when one of the following events occurs:</td>
<td>When an event takes place (for example, a birth, marriage, determination of eligibility for state subsidy), coverage begins on the date of the event if we receive the completed enrollment form and any required Premium within 31 days of the event unless otherwise noted above.</td>
</tr>
</tbody>
</table>

Special Enrollment Period

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.

• Birth.
• Legal adoption.
• Placement for adoption.
• Marriage.
• Registering a Domestic Partner.
• Involuntary termination of spouse's coverage under another plan.
• A court order or the support enforcement agency order requiring the Eligible Person to provide health care coverage for a child. If an Eligible Person is not enrolled and is required under a court or agency order to provide such coverage for a child, the Eligible Person will be allowed to enroll when including the child pursuant to the order.

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 because they had existing health coverage under another plan, coverage begins on the day immediately following the day coverage under the prior plan ends. Except as otherwise noted above, coverage will begin only if we receive the completed enrollment form and any required Premium within 31 days of the date coverage under the prior plan ended.

When an event takes place (for example, a birth, marriage, determination of eligibility for state subsidy), coverage begins on the date of the event if we receive the completed enrollment form and any required Premium within 31 days of the event unless otherwise noted above.
When to Enroll | Who Can Enroll | Begin Date
---|---|---
Enrollment Period if 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, but not limited to, 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 lives or works in an HMO service area if no other benefit option is available.
### When to Enroll

<table>
<thead>
<tr>
<th>When to Enroll</th>
<th>Who Can Enroll</th>
<th>Begin Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>- The plan no longer offers benefits to a class of individuals that include the Eligible Person and/or Dependent.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- An Eligible Person and/or Dependent incurs a claim that would exceed a lifetime limit on all benefits.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- 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.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Section 10: Glossary of Defined Terms

The definitions of Alternate Facility, Covered Health Services, Experimental or Investigational Service(s), Mental Health Services, Mental Health/Substance Abuse Designee, Mental Illness, Primary Physician, and Sickness, and Specialist Physician and Substance Abuse Services under (Section 10: Glossary of Defined Terms) are deleted and replaced with the following:

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

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

An Alternate Facility may also provide Mental Health Services or Substance Use Disorder Services on an outpatient or inpatient basis.

**Covered Health Service(s)** - those health services, including services, supplies, or pharmaceutical products, which we determine to be all of the following:

- Provided for the purpose of preventing, diagnosing or treating a Sickness, Injury, Mental Illness, substance use disorders, or their symptoms.
- Consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below.
- Not provided for the convenience of the Covered Person, Physician, facility or any other person.
- Described in (Section 1: What's Covered--Benefits) as a Covered Health Service.
- Not otherwise excluded in the Certificate under (Section 2: What's Not Covered--Exclusions).

In applying the above definition, "scientific evidence" and "prevailing medical standards" shall have the following meanings:

- "Scientific evidence" means the results of controlled clinical trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community.
- "Prevailing medical standards and clinical guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.

We maintain clinical protocols that describe the scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical protocols (as revised from time to time), are available to Covered Persons on www.myuhc.com or by calling Customer Service at the telephone.
number on your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.

**Experimental or Investigational Service(s)** - medical, surgical, diagnostic, psychiatric, mental health, substance use 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.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are FDA approved under the Humanitarian Use Device exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exception:

- Life-Threatening Sickness or Condition. 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, in our discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the National Institutes of Health.

**Mental Health Services** - Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment for the condition is a Covered Health Service.

**Mental Health/Substance Use Disorder Designee** - the organization or individual, designated by us, that provides or arranges Mental Health Services and Substance Use Disorder Services for which Benefits are available under the Policy.

**Mental Illness** - those mental health or psychiatric diagnostic categories that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded under the Policy.

**Primary Physician** - a Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine. For Mental Health Services and Substance Use Disorder Services, any licensed clinician is considered on the same basis as a Primary Physician for the provision of all services other than psychological testing.

**Sickness** - physical illness, disease or Pregnancy. The term Sickness as used in the Certificate does not include Mental Illness or substance use disorders, regardless of the cause or origin of the Mental Illness or substance use disorder.

**Specialist Physician** - 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. For
Mental Health Services and Substance Use Disorder Services, any licensed clinician is considered on the same basis as a Specialist Physician. For Mental Health Services and Substance Use Disorder Services, a licensed clinician who provides psychological testing is considered on the same basis as a Specialist Physician.

**Substance Use Disorder Services** - Covered Health Services for the diagnosis and treatment of alcoholism and substance use disorders that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded. The fact that a disorder is listed in the Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment of the disorder is a Covered Health Service.

**The following definitions of Alcohol Abuse, Autism Spectrum Disorders, Drug Abuse, Intensive Outpatient Treatment, Partial Hospitalization/Day Treatment, Residential Treatment Facility and Transitional Care are added under (Section 10: Glossary of Defined Terms):**

**Alcohol Abuse** - 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.

**Autism Spectrum Disorders** - a group of neurobiological disorders that includes Autistic Disorder, Rhett's Syndrome, Asperger's Disorder, Childhood Disintegrated Disorder, and Pervasive Development Disorders Not Otherwise Specified (PDDNOS).

**Drug Abuse** - a disease that is characterized by a pattern of pathological use of a drug 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.

**Intensive Outpatient Treatment** - a structured outpatient Mental Health or Substance Use Disorder treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

**Partial Hospitalization/Day Treatment** - the provision of medically directed intensive or intermediate short-term treatment for mental illness, emotional disorders, drug abuse or alcohol abuse for a period of less than 24 hours but more than 4 hours in a day for a member or subscriber in a licensed or certified facility or program.

**Residential Treatment Facility** - a facility which provides a program of effective Mental Health Services or Substance Use Disorder Services treatment and which meets all of the following requirements:

- It is established and operated in accordance with applicable state law for residential treatment programs.
- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance Use Disorder Designee.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu:
  — 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.

**Transitional Care** - Mental Health Services and Substance Use Disorder Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing, alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

- Supervised living arrangements which are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

OPTIMUM CHOICE, INC.

James P. Cronin, Jr. CEO
As described in this Amendment, the Policy is modified to provide a revised definition of Dependent.

To the extent this Amendment may conflict with any Amendment issued to you previously, the provisions of this Amendment will govern.

Because this Amendment 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 10: Glossary of Defined Terms) and in this Amendment below.
Section 10: Glossary of Defined Terms

The definition of Dependent in the Certificate under (Section 10: Glossary of Defined Terms) is replaced with the following:

**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. The term child includes any of the following:

- 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 as that term is used in 26 U.S.C. §§ 104, 105, and 106, and any regulations adopted under those sections.
- 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.

The definition of Dependent is subject to the following conditions and limitations:

- A Dependent includes any child listed above under 26 years of age.
- A Dependent includes an unmarried dependent child age 26 or older who is or becomes mentally or physically incapacitated and dependent upon the Subscriber.

The Subscriber must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy these conditions.

A Dependent also includes 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 terminate 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 for or is eligible to receive benefits under the Maryland Medical Assistance Program.

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

OPTIMUM CHOICE, INC.

James P. Cronin, Jr. CEO
Optimum Choice, Inc.

Outpatient Prescription Drug Rider

Optimum Choice, Inc.
4 Taft Court
Rockville, MD  20850
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Outpatient Prescription Drug Rider

This Rider to the Policy is issued to the Enrolling Group and provides Benefits for outpatient Prescription Drug Products.

Benefits are provided for outpatient Prescription Drug Products at a Network Pharmacy.

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 (Section 10: Glossary of Defined Terms) of the Certificate of Coverage and in (Section 3: Glossary of Defined Terms) of this Rider.

When we use the words "we," "us," and "our" in this document, we are referring to Optimum Choice, 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 of Coverage (Section 10: Glossary of Defined Terms).

NOTE: The Coordination of Benefits provision (Section 7: Coordination of Benefits) in the Certificate of Coverage does not apply to Prescription Drug Products covered through this Rider. Prescription Drug Product Benefits will not be coordinated with those of any other health coverage plan.

James P. Cronin, Jr. CEO
Introduction

Benefits for Outpatient Prescription Drug Products

Benefits are available for Outpatient Prescription Drug Products on our Prescription Drug List at a Network Pharmacy and are subject to Copayments or other payments that vary depending on which of the three tiers of the Prescription Drug List the Outpatient Prescription Drug is listed.

Coverage Policies and Guidelines

Our Prescription Drug List ("PDL") Management Committee is authorized to make tier placement changes on our behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether supply limits or notification requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, available rebates, and assessments on the cost effectiveness of the Prescription Drug Product.

We may periodically change the placement of a Prescription Drug Product among the tiers. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to you.

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 an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

NOTE: The tier status of a Prescription Drug Product may change periodically 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 access www.myuhc.com through the Internet, or call the Customer Service number on your ID card for the most up-to-date tier status.

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 will be required to 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 of Coverage (Section 5: How to File a Claim). When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription
Drug Cost, less the required Copayment and any deductible that applies.

**Limitation on 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 selection of Network Pharmacies may be limited. If this happens, we may require you to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within thirty-one (31) days of the date we notify you, we will select a single Network Pharmacy for you.

**Rebates and Other Payments to Us**
We may receive rebates for certain drugs included on our Prescription Drug List. We do not consider these rebates in calculating any percentage Copayments. We are not required to pass on to you, and we do not pass on to you, amounts payable to us under rebate programs or other such discounts.

We, and a number of our affiliated entities, conduct business with various 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 we do not pass on to you, such amounts.
Section 1: What's Covered--Prescription Drug Benefits

Benefits for Outpatient Prescription Drug Products
Benefits for outpatient Prescription Drug Products are available when the outpatient Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

Benefits for Prescription Drug Products are available for smoking cessation when prescribed by an Authorized Prescriber for smoking cessation treatment. This includes (1) any Prescription Drug Product that is approved by the Food and Drug Administration as an aid for the cessation of the use of tobacco products and (2) Prescription Drug Products defined as Nicotine Replacement Therapy. These benefits are subject to the following limitation: Nicotine Replacement Therapy is limited to two 90-day courses of treatment per calendar year.

When a Brand-name Drug Becomes Available as a Generic
When a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment may change. You will pay the Copayment applicable for the tier to which the Prescription Drug Product is assigned.

Supply Limits
Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description of Pharmacy Type and Supply Limits" column of the Benefit Information table. For a single Copayment, 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, subject to our periodic review and modification. The limit may restrict 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).
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 Copayment for the supply that exceeds the limit.

You may determine whether a Prescription Drug Product has been assigned a maximum quantity level for dispensing through the Internet at www.myuhc.com or by calling Customer Service at the telephone number on your ID card.

**Notification Requirements**

Before certain Prescription Drug Products are dispensed to you, either your Physician, your pharmacist or you are required to notify us or our designee. The reason for notifying 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 Service.
- It is not Experimental, Investigational or Unproven.

**Network Pharmacy Notification**

When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for notifying us.

If we are not notified before the Prescription Drug Product is dispensed, you may pay more for that Prescription Order or Refill. The Prescription Drug Products requiring notification are subject to our periodic review and modification. You may determine whether a particular Prescription Drug Product requires notification through the Internet at www.myuhc.com or by calling the Customer Service number on your ID card.

If we are not notified before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Certificate of Coverage (Section 5: How to File a Claim).

When you submit a claim on this basis, you may pay more because you did not notify us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Cost, less the required Copayment and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is Experimental, Investigational or Unproven.

**What You Must Pay**

You are responsible for paying the applicable Copayment described in the Benefit Information table when Prescription Drug Products are obtained from a retail or home delivery pharmacy.

The amount you pay for any of the following under this Rider will not be included in calculating any Out-of-Pocket Maximum stated in your Certificate of Coverage:

- Copayments for Prescription Drug Products.
- 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 and our contracted rates (our Prescription Drug Cost) will not be available to you.
Payment Information

<table>
<thead>
<tr>
<th>Payment Term</th>
<th>Description</th>
<th>Amounts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copayment</td>
<td>Copayments for a Prescription Drug Product at a Network Pharmacy can be either a specific dollar amount or a percentage of the Prescription Drug Cost. Your Copayment is determined by the tier to which the Prescription Drug List Management Committee has assigned a Prescription Drug Product. NOTE: The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List Management Committee's periodic tiering decisions. When that occurs, your Copayment may change. Please access <a href="http://www.myuhc.com">www.myuhc.com</a> through the Internet, or call the Customer Service number on your ID card for the most up-to-date tier status.</td>
<td>For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment or • The Network Pharmacy's Usual and Customary Charge (which includes a dispensing fee and sales tax) for the Prescription Drug Product. For Prescription Drug Products from a home delivery Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment or • The Prescription Drug Cost for that Prescription Drug Product. See the Copayments stated in the Benefit Information table for amounts.</td>
</tr>
</tbody>
</table>
### Benefit Information

<table>
<thead>
<tr>
<th>Description of Pharmacy Type and Supply Limits</th>
<th>Your Copayment Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prescription Drugs from a Retail or Home Delivery Network Pharmacy</strong></td>
<td></td>
</tr>
</tbody>
</table>

Benefits are provided for outpatient Prescription Drug Products dispensed by a retail or home delivery Network Pharmacy. The term "home delivery pharmacy" means a pharmacy that delivers Prescription Drug Products to consumers by means of a mail order.

The following supply limits apply:

- As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.

- A one-cycle supply of an oral contraceptive. You may obtain up to three cycles at one time if you pay a Copayment for each cycle supplied.

- For Maintenance Medications, as written by the provider:
  - up to a consecutive 31 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 (for the payment of a Copayment up to 2.5 times the Copayment for a 31 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 the guidance for early refill of topical ophthalmic product provided to Medicare Part D plan sponsors by the Centers for Medicare and Medicaid Services; 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

Your Copayment is determined by the tier to which the Prescription Drug List Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1, Tier-2 or Tier-3. Please access www.myuhc.com through the Internet, or call the Customer Service number on your ID card to determine tier status.

**Retail or Home Delivery Pharmacy non-Maintenance Medications and the first prescription or a change in prescription of a Maintenance Medication**

- $10.00 per Prescription Order or Refill for a Tier-1 Prescription Drug Product.

- $30.00 per Prescription Order or Refill for a Tier-2 Prescription Drug Product.
<table>
<thead>
<tr>
<th>Description of Pharmacy Type and Supply Limits</th>
<th>Your Copayment Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>exceed the number of additional quantities indicated on the original Prescription Order or Refill.</td>
<td>$50.00 per Prescription Order or Refill for a <strong>Tier-3</strong> Prescription Drug Product.</td>
</tr>
<tr>
<td>Up to a 90-day supply of Retail or Home Delivery Pharmacy Maintenance Medications after the first prescription or a change in prescription</td>
<td>$20.00 per Prescription Order or Refill for a <strong>Tier-1</strong> Prescription Drug Product.</td>
</tr>
<tr>
<td>$60.00 per Prescription Order or Refill for a <strong>Tier-2</strong> Prescription Drug Product.</td>
<td>$100.00 per Prescription Order or Refill for a <strong>Tier-3</strong> Prescription Drug Product.</td>
</tr>
</tbody>
</table>
Section 2: What's Not Covered--Exclusions

Exclusions from coverage listed in the Certificate apply also to this Rider. In addition, the following exclusions apply:

1. Outpatient Prescription Drug Products obtained from a non-Network Pharmacy except as a result of (1) an emergency or urgent care received out of the Service Area, or (2) the Covered Person is covered by a point of service plan under the Policy.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
4. Drugs which are prescribed, dispensed or intended for use while you are an inpatient in a Hospital, Skilled Nursing Facility, or Alternate Facility.
5. Experimental, Investigational or Unproven Services and medications; medications used for experimental indications 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 drug if such drug is recognized for treatment in any of the standard reference compendia or in the medical literature.
6. 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.
7. 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.
8. Any product dispensed for the purpose of appetite suppression and other weight loss products.
9. A specialty medication Prescription Drug Product (including, but not limited to, immunizations and allergy serum) which, due to its characteristics as determined by us, must typically be administered or supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
10. Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
11. General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.
12. Unit dose packaging of Prescription Drug Products.
13. Medications used for cosmetic purposes.
14. Prescription Drug Products, including New Prescription Drug Products or new dosage forms that are determined to not be a Covered Health Service.
15. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
16. Prescription Drug Products when prescribed to treat infertility, except clomiphene. Notwithstanding this exclusion, if in vitro fertilization is covered under the medical benefits, and the procedure has been authorized, Prescription Drug Products associated with the procedure are covered.

17. Prescription Drug Products when prescribed to prevent conception, including oral contraceptives, diaphragms, Depo Provera and other injectable drugs used for contraception.

18. Compounded drugs that do not contain at least one ingredient that requires a Prescription Order or Refill. Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier-3.

19. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed. Any Prescription Drug Product that is therapeutically equivalent to an over-the-counter drug. Prescription Drug Products that are comprised of components that are available in over-the-counter form or equivalent.

Note: 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 the Covered Person's disease or condition; or
  - Has caused or is likely to cause an adverse reaction or other harm to the Covered Person.

20. New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by our Prescription Drug List Management Committee. However, we will provide immediate coverage for a New Prescription Drug Product if, in the judgement 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 the Covered Person's disease or condition; or
  - has caused or is likely to cause an adverse reaction or other harm to the Covered Person.

21. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
Section 3: Glossary of Defined Terms

This section:
- Defines the terms used throughout this Rider.
  Other defined terms used throughout this Rider can be found in (Section 10: Glossary of Defined Terms) of your Certificate of Coverage.
- Is not intended to describe Benefits.

Authorized Prescriber - has the meaning stated in Section 12-101 of the Health Occupations Article in 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 including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by us.

Designated Pharmacy - a pharmacy that has entered into an agreement on behalf of the pharmacy with us or with an organization contracting on our behalf, to provide specific Drug Products. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

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 including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by us.

Maintenance Medication - a drug anticipated to be required for 6 months or more to treat a chronic condition.

Network Pharmacy - a pharmacy that has:
- Entered into an agreement with us or our designee to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by us as a Network Pharmacy.

A Network Pharmacy can be either a retail or a home delivery 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 FDA, and ending on the earlier of the following dates:
- The date it is assigned to a tier by our Prescription Drug List Management Committee.
- December 31st of the following calendar year.
**Nicotine Replacement Therapy** - a Prescription Drug Product that: (1) is used to deliver nicotine to an individual attempting to cease the use of tobacco products; (2) is obtained under a prescription written by an Authorized Prescriber; and (3) does not include any over-the-counter product that may be obtained without a prescription.

**Prescription Drug Cost** - the rate we have agreed to pay our Network Pharmacies, including a dispensing fee and any sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

**Prescription Drug List** - a list that identifies those Prescription Drug Products for which Benefits are available under this Rider. This list is subject to our periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Prescription Drug Product has been assigned through the Internet at www.myuhc.com or by calling the Customer Service number on your ID card.

**Prescription Drug List Management Committee** - the committee that we designate for, among other responsibilities, classifying Prescription Drug Products into specific tiers.

**Prescription Drug Product** - a medication, product or device that has been approved by the Food and Drug Administration and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, 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.
- 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;
  - glucose monitors.

**Prescription Order or Refill** - the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

**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.

- End of Outpatient Prescription Drug Rider -
Important Notices under the Patient Protection and Affordable Care Act (PPACA)

IMPORTANT NOTICE: If you have a dependent child whose coverage ended or who was denied coverage (or was not eligible for coverage) because dependent coverage of children was not available up to age 26, you may have the right to enroll that dependent under a special dependent child enrollment period. This right applies as of the first day of the first plan year beginning on or after September 23, 2010 and your employer (or enrolling group) must provide you with at least a 30 day enrollment period. If you are adding a dependent child during this special enrollment period and have a choice of coverage options under the plan, you will be allowed to change options. This child special open enrollment may coincide with your annual open enrollment, if you have one. Please contact your employer or group plan administrator for more information.

IMPORTANT NOTICE: If coverage or benefits for you or a dependent ended due to reaching a lifetime limit, be advised that a lifetime limit on the dollar value of benefits no longer applies. If you are covered under the plan, you are once again eligible for benefits. Additionally, if you are not enrolled in the plan, but are still eligible for coverage, then you will have a 30 day opportunity to request enrollment. This 30 day enrollment opportunity will begin no later than the first day of the first plan year beginning on or after September 23, 2010. This 30 day enrollment period may coincide with your annual open enrollment, if you have one. Please contact your employer or group health plan administrator for more information.
Changes in Federal Law that Impact Benefits

There are changes in Federal law which may impact coverage and Benefits stated in the *Certificate of Coverage (Certificate)*. A summary of those changes and the dates the changes are effective appear below.

**Patient Protection and Affordable Care Act (PPACA)**

Effective for policies that are new or renewing on or after September 23, 2010, the requirements listed below apply.

- **Lifetime limits on the dollar amount of essential benefits available to you under the terms of your plan are no longer permitted.** Essential benefits include the following:
  - Ambulatory patient services; emergency services, hospitalization; maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.
  - On or before the first day of the first plan year beginning on or after September 23, 2010, the enrolling group will provide a 30 day enrollment period for those individuals who are still eligible under the plan's eligibility terms but whose coverage ended by reason of reaching a lifetime limit on the dollar value of all benefits.

- **Essential benefits for plan years beginning prior to January 1, 2014 can only be subject to restricted annual limits.** Restricted annual limits for each person covered under the plan may be no less than the following:
  - For plan or policy years beginning on or after September 23, 2010 but before September 23, 2011, $750,000.
  - For plan or policy years beginning on or after September 23, 2011 but before September 23, 2012, $1,250,000.
  - For plan or policy years beginning on or after September 23, 2012 but before January 1, 2014, $2,000,000.

- **Any pre-existing condition exclusions (including denial of benefits or coverage) will not apply to covered persons under the age of 19.**

- **Coverage for enrolled dependent children is no longer conditioned upon full-time student status or other dependency requirements and will remain in place until the child's 26th birthday.** If you have a grandfathered plan, the enrolling group is not required to extend coverage to age 26 if the child is eligible to enroll in an eligible employer-sponsored health plan (as defined by law). Under the *PPACA* a plan generally is "grandfathered" if it was in effect on March 23, 2010 and there are no substantial changes in the benefit design as described in the *Interim Final Rule on Grandfathered Health Plans.*

  On or before the first day of the first plan year beginning on or after September 23, 2010, the enrolling group will provide a 30 day dependent child special open enrollment period for dependent children who are not currently enrolled under the policy and who have not yet reached age 26. During this
dependent child special open enrollment period, subscribers who are adding a dependent child and who have a choice of coverage options will be allowed to change options.

- If your plan includes coverage for enrolled dependent children beyond the age of 26, which is conditioned upon full-time student status, the following applies:

  Coverage for enrolled dependent children who are required to maintain full-time student status in order to continue eligibility under the policy is subject to the statute known as Michelle’s Law. This law amends ERISA, the Public Health Service Act, and the Internal Revenue Code and requires group health plans, which provide coverage for dependent children who are post-secondary school students, to continue such coverage if the student loses the required student status because he or she must take a medically necessary leave of absence from studies due to a serious illness or Injury.

- If you do not have a grandfathered plan, benefits for preventive care services described below will be paid at 100%, and not subject to any deductible, coinsurance or copayment. If you have pharmacy benefit coverage, your plan may also be required to cover preventive care medications that are obtained at a network pharmacy at 100%, and not subject to any deductible, coinsurance or copayment, 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.

  — 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.

- Retroactive rescission of coverage under the policy is permitted, with 30 days advance written notice, only in the following two circumstances:

  — The individual performs an act, practice or omission that constitutes fraud.

  — The individual makes an intentional misrepresentation of a material fact.

- Other changes provided for under the PPACA do not impact your plan because your plan already contains these benefits. These include:

  — Direct access to OB/GYN care without a referral or authorization requirement.

  — The ability to designate a pediatrician as a primary care physician (PCP) if your plan requires a PCP designation.

  — Prior authorization is not required before you receive services in the emergency department of a hospital.

If you seek emergency care from out-of-network providers in the emergency department of a hospital your cost sharing obligations (copayments/coinsurance) will be the same as would be applied to care received from in-network providers.
Some Important Information about Appeal and External Review Rights under PPACA

If you are enrolled in a non-grandfathered plan with an effective date or plan year anniversary on or after September 23, 2010, the Patient Protection and Affordable Care Act of 2010 (PPACA), as amended, sets forth new and additional internal appeal and external review rights beyond those that some plans may have previously offered. Also, certain grandfathered plans are complying with the additional internal appeal and external review rights provisions on a voluntary basis. Please refer to your benefit plan documents, including amendments and notices, or speak with your employer or UnitedHealthcare for more information on the appeal rights available to you. (Also, please refer to the Claims and Appeal Notice section of this document.)

What if I receive a denial, and need help understanding it? Please call UnitedHealthcare at the number listed on the back of your health plan ID card.

What if I don't agree with the denial? You have a right to appeal any decision to not pay for an item or service.

How do I file an appeal? The initial denial letter or Explanation of Benefits that you receive from UnitedHealthcare will give you the information and the timeframe to file an appeal.

What if my situation is urgent? If your situation is urgent, your review will be conducted as quickly as possible. If you believe your situation is urgent, you may request an expedited review, and, if applicable, file an external review at the same time. For help call UnitedHealthcare at the number listed on the back of your health plan ID card.

Generally, an urgent situation is when your health may be in serious jeopardy. Or when, in the opinion of your doctor, you may be experiencing severe pain that cannot be adequately controlled while you wait for a decision on your appeal.

Who may file an appeal? Any member or someone that member names to act as an authorized representative may file an appeal. For help call UnitedHealthcare at the number listed on the back of your health plan ID card.

Can I provide additional information about my claim? Yes, you may give us additional information supporting your claim. Send the information to the address provided in the initial denial letter or Explanation of Benefits.

Can I request copies of information relating to my claim? Yes. There is no cost to you for these copies. Send your request to the address provided in the initial denial letter or Explanation of Benefits.

What happens if I don't agree with the outcome of my appeal? If you appeal, we will review our decision. We will also send you our written decision within the time allowed. If you do not agree with the decision, you may be able to request an external review of your claim by an independent third party. They will review the denial and issue a final decision.

If I need additional help, what should I do? For questions on your appeal rights, you may call UnitedHealthcare at the number listed on the back of your health plan ID card. You may also contact the support groups listed below.

Are verbal translation services available to me during an appeal? Yes. Contact UnitedHealthcare at the number listed on the back of your health plan ID card. Ask for verbal translation services for your questions.
Is there other help available to me? For questions about appeal rights, an unfavorable benefit decision, or for help, you may also contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272). Your state consumer assistance program may also be able to help you.

For information on appeals and other PPACA regulations, visit www.healthcare.gov.

Americans with Disabilities Act
Effective for Policies that are new or renewing on or after October 3, 2009, changes in interpretation of the Americans with Disabilities Act result in the following additional Benefits:

- Benefits are provided for hearing aids required for the correction of a hearing impairment and for charges for associated fitting and testing.
  
  Benefits for hearing aids are subject to payment requirements (Copayment, Annual Deductible and Out-of-Pocket Maximums) and annual limits that mirror those applicable to Durable Medical Equipment and Prosthetic Devices as shown in the Certificate, however Benefits for hearing aids will never exceed $5,000 per year.

- Benefits for bone anchored hearing aids are a Covered Health Service for which Benefits are provided under the applicable medical/surgical Benefit categories in the Certificate only for Covered Persons who have either of the following:
  
  — Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
  
  — Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

Benefits for bone anchor hearing aids are limited to one per Covered Person during the entire period of time the Covered Person is enrolled under the Policy, and include repairs and/or replacement only if the bone anchor hearing aid malfunctions.

Mental Health/Substance Use Disorder Parity
Effective for Policies that are new or renewing on or after July 1, 2010, Benefits are subject to final regulations supporting the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Benefits for mental health conditions and substance use disorder conditions that are Covered Health Services under the Policy must be treated in the same manner and provided at the same level as Covered Health Services for the treatment of other Sickness or Injury. Benefits for Mental Health Services and Substance Use Disorder Services are not subject to any annual maximum benefit limit (including any day, visit or dollar limit).

MHPAEA requires that the financial requirements for coinsurance and copayments for mental health and substance use disorder conditions must be no more restrictive than those coinsurance and copayment requirements for substantially all medical/surgical benefits. MHPAEA requires specific testing to be applied to classifications of benefits to determine the impact of these financial requirements on mental health and substance use disorder benefits. Based upon the results of that testing, it is possible that coinsurance or copayments that apply to mental health conditions and substance use disorder conditions in your benefit plan may be reduced.

Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)
Effective April 1, 2009, the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) expands special enrollment rights under the Policy.

An Eligible Person and/or Dependent may 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 was terminated for cause or because premiums were not paid on a timely basis.

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

- The Eligible Person and/or Dependent had existing health coverage under Medicaid or Children's Health Insurance Program (CHIP) 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 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.

- 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.
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 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; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health 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 precertification. For information on precertification, contact your issuer.
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 15 days after the information is received. If you don’t provide the needed information within the 45-day period, your claim will be denied.

A denial notice will 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 in accordance with the applicable claim filing procedures. If you pay a Copayment and believe that the amount of the Copayment was incorrect, you also may submit a claim for reimbursement in accordance with 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, you will receive 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 in accordance with 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; or
- 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 contact our Customer Service department before requesting a formal appeal. If the Customer Service 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 Customer Service representative. If you first informally contact our Customer Service department and later wish to request a formal appeal in writing, you should again contact Customer Service and request an appeal. If you request a formal appeal, a Customer Service 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 our Customer Service department immediately.

**How to 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 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 claim denial.

**Appeal Process**

A qualified individual who was not involved in the decision being appealed will be appointed 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 appropriate expertise in the field, who was not involved in the prior determination. We may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent 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 relevant to your claim for Benefits. In addition, 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 and sufficiently 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 identified above, the first level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for appeal of a denied request for Benefits. The second level appeal will be conducted 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 identified above, the first level appeal will be conducted and you will be notified of the
decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted 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 associated with urgent requests for Benefits, see Urgent Appeals that Require Immediate Action below.

If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to us within 60 days from receipt of the first level appeal decision.

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure. We don't determine whether the pending health service is necessary or appropriate. That decision is between you and your Physician.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly 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.
Changes Required By Final HIPAA Regulations

Changes required by the final HIPAA Portability Regulations are effective July 1, 2005. Those changes include clarification of the requirements for a Special Enrollment Period and Continuous Creditable Coverage as described 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 was terminated 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 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.

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

- 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 any applicable Open Enrollment Period; and
- Coverage under the prior plan ended because of any of the following:
  — Loss of eligibility (including, without limitation, 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 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 include the Eligible Person and/or Dependent.
  — An Eligible Person and/or Dependent incurs a claim that would exceed a lifetime limit on all benefits.

Continuous Creditable Coverage
Continuous Creditable Coverage is defined as health care coverage under any of the types of plans listed below, during which there was no break in coverage of 63 consecutive days or more:

- A group health plan.
- Health insurance coverage.
- Medicare.
- Medicaid.
- Medical and dental care for members and certain former members of the uniformed services, and for their dependents.
- A medical care program of the Indian Health Services Program or a tribal organization.
- A state health benefits risk pool.
- The Federal Employees Health Benefits Program.
- The State Children's Health Insurance Program (S-CHIP).
- Health plans established and maintained by foreign governments or political subdivisions and by the U.S. government.
- Any public health benefit program provided by a state, county, or other political subdivision of a state.
- A health benefit plan under the Peace Corps Act.

A waiting period for health care coverage will be included in the period of time counted as Continuous Creditable Coverage.

**Maximum Policy Benefit**

The terms of your Certificate of Coverage may define and establish terms relating to a Maximum Policy Benefit. This maximum policy benefit may impose a preexisting condition limitation under the updated HIPAA Portability regulations.
Continuation Coverage under Federal Law (COBRA)

Much of the language in this section comes from the federal law that governs continuation coverage. You should call your Enrolling Group's plan administrator if you have questions about your right to continue coverage.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who was covered under the Policy on the day before a qualifying event:

- A Subscriber.
- A Subscriber's Enrolled Dependent, including with respect to the Subscriber's children, a child born to or placed for adoption with the Subscriber during a period of continuation coverage under federal law.
- A Subscriber's former spouse.

Qualifying Events for Continuation Coverage under Federal Law (COBRA)

If the coverage of a Qualified Beneficiary would ordinarily terminate due to one of the following qualifying events, then the Qualified Beneficiary is entitled to continue coverage. The Qualified Beneficiary is entitled to elect the same coverage that she or he had on the day before the qualifying event.

The qualifying events with respect to an employee who is a Qualified Beneficiary are:

A. Termination of the Subscriber from employment with the Enrolling Group, for any reason other than gross misconduct.
B. Reduction in the Subscriber's hours of employment.

With respect to a Subscriber's spouse or dependent child who is a Qualified Beneficiary, the qualifying events are:

A. Termination of the Subscriber from employment with the Enrolling Group, for any reason other than the Subscriber's gross misconduct.
B. Reduction in the Subscriber's hours of employment.
C. Death of the Subscriber.
D. Divorce or legal separation of the Subscriber.
E. Loss of eligibility by an Enrolled Dependent who is a child.
F. Entitlement of the Subscriber to Medicare benefits.
G. The Enrolling Group filing for bankruptcy, under Title 11, United States Code. This is also a qualifying event for any retired Subscriber and his or her Enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.
Notification Requirements and Election Period for Continuation Coverage under Federal Law (COBRA)

Notification Requirements for Qualifying Event
The Subscriber or other Qualified Beneficiary must notify the Enrolling Group's plan administrator within 60 days of the latest of the date of the following events:

- The Subscriber's divorce or legal separation, or an Enrolled Dependent's loss of eligibility as an Enrolled Dependent.
- The date the Qualified Beneficiary would lose coverage under the Policy.
- The date on which the Qualified Beneficiary is informed of his or her obligation to provide notice and the procedures for providing such notice.

The Subscriber or other Qualified Beneficiary must also notify the Enrolling Group's plan administrator when a second qualifying event occurs, which may extend continuation coverage.

If the Subscriber or other Qualified Beneficiary fails to notify the Enrolling Group's plan administrator of these events within the 60 day period, the plan administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If a Subscriber is continuing coverage under federal law, the Subscriber must notify the Enrolling Group's plan administrator within 60 days of the birth or adoption of a child.

Notification Requirements for Disability Determination or Change in Disability Status
The Subscriber or other Qualified Beneficiary must notify the Enrolling Group's plan administrator as described under "Terminating Events for Continuation Coverage under Federal Law (COBRA)," subsection A. below.

The notice requirements will be satisfied by providing written notice to the Enrolling Group's plan administrator at the address stated in the ERISA Statement. The contents of the notice must be such that the plan administrator is able to determine the covered employee and Qualified Beneficiary or Beneficiaries, the qualifying event or disability, and the date on which the qualifying event occurred.

None of the above notice requirements will be enforced if the Subscriber or other Qualified Beneficiary is not informed of his or her obligations to provide such notice.

After providing notice to the Enrolling Group's plan administrator, the Qualified Beneficiary shall receive the continuation coverage and election notice. Continuation coverage must be elected by the later of 60 days after the qualifying event occurs; or 60 days after the Qualified Beneficiary receives notice of the continuation right from the plan administrator.

The Qualified Beneficiary's initial premium due to the plan administrator must be paid on or before the 45th day after electing continuation.

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain employees who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals; generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from...
the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If you qualify or may qualify for assistance under the Trade Act of 1974, contact the Enrolling Group for additional information. You must contact the Enrolling Group promptly after qualifying for assistance under the Trade Act of 1974 or you will lose your special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that plan coverage was lost but begins on the first day of the special second election period.

**Terminating Events for Continuation Coverage under Federal Law (COBRA)**

Continuation under the Policy will end on the earliest of the following dates:

A. Eighteen months from the date of the qualifying event, if the Qualified Beneficiary's coverage would have ended because the Subscriber's employment was terminated or hours were reduced (i.e., qualifying events A and B).

If a Qualified Beneficiary is determined to have been disabled under the Social Security Act at any time within the first 60 days of continuation coverage for qualifying event A or B then the Qualified Beneficiary may elect an additional eleven months of continuation coverage (for a total of twenty-nine months of continued coverage) subject to the following conditions:

— Notice of such disability must be provided within the latest of 60 days after:
  ♦ the determination of the disability; or
  ♦ the date of the qualifying event; or
  ♦ the date the Qualified Beneficiary would lose coverage under the Policy; and
  ♦ in no event later than the end of the first eighteen months.

— The Qualified Beneficiary must agree to pay any increase in the required Premium for the additional eleven months.

— If the Qualified Beneficiary who is entitled to the eleven months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional eleven months of continuation coverage.

Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

B. Thirty-six months from the date of the qualifying event for an Enrolled Dependent whose coverage ended because of the death of the Subscriber, divorce or legal separation of the Subscriber, or loss of eligibility by an Enrolled Dependent who is a child (i.e. qualifying events C, D, or E).

C. With respect to Qualified Beneficiaries, and to the extent that the Subscriber was entitled to Medicare prior to the qualifying event:

— Eighteen months from the date of the Subscriber's Medicare entitlement; or

— Thirty-six months from the date of the Subscriber's Medicare entitlement, if a second qualifying event (that was due to either the Subscriber's termination of employment or
the Subscriber's work hours being reduced) occurs prior to the expiration of the eighteen months.

D. With respect to Qualified Beneficiaries, and to the extent that the Subscriber became entitled to Medicare subsequent to the qualifying event:

- Thirty-six months from the date of the Subscriber's termination from employment or work hours being reduced (first qualifying event) if:
  - The Subscriber's Medicare entitlement occurs within the eighteen month continuation period; and
  - If, absent the first qualifying event, the Medicare entitlement would have resulted in a loss of coverage for the Qualified Beneficiary under the group health plan.

E. The date coverage terminates under the Policy for failure to make timely payment of the Premium.

F. The date, after electing continuation coverage, that coverage is first obtained under any other group health plan. If such coverage contains a limitation or exclusion with respect to any pre-existing condition, continuation shall end on the date such limitation or exclusion ends. The other group health coverage shall be primary for all health services except those health services that are subject to the pre-existing condition limitation or exclusion.

G. The date, after electing continuation coverage, that the Qualified Beneficiary first becomes entitled to Medicare, except that this shall not apply in the event that coverage was terminated because the Enrolling Group filed for bankruptcy, (i.e. qualifying event G). If the Qualified Beneficiary was entitled to continuation because the Enrolling Group filed for bankruptcy, (i.e. qualifying event G) and the retired Subscriber dies during the continuation period, then the other Qualified Beneficiaries shall be entitled to continue coverage for thirty-six months from the date of the Subscriber's death.

H. The date the entire Policy ends.

I. The date coverage would otherwise terminate under the Policy as described in the Certificate of Coverage (Section 8: When Coverage Ends) under the heading *Events Ending Your Coverage.*
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.

We* 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.

*For purposes of this Notice of Privacy Practices, "we" or "us" refers to the following health plans that are affiliated with UnitedHealth Group:

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 condition, the provision of health care to you, or the payment for such health care.

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 a revised notice by direct mail or electronically as permitted by applicable law. In all cases, we will post the revised notice on our website www.myuhc.com. We reserve the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

How We Use or Disclose Information

We must 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; and
- 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 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 use or disclose health information to aid in your treatment or the coordination of your care. For example, we may disclose information to your physicians or hospitals to help them provide medical care to you.
- For Health Care Operations. We may use or disclose health information as necessary 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.
- 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 if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with federal law.
• 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.

We may use or 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 use or 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.

• For Public Health Activities such as reporting or preventing disease outbreaks.

• 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 evaluation of certain treatments or the prevention of disease or disability, if the research study meets 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 necessary to carry out their duties.

• For Organ Procurement Purposes. We may use or 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 necessary (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 necessary for such functions or services. Our business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

For Data Breach Notification Purposes. We may use your contact information to provide legally-required notices of unauthorized acquisition, access, or disclosure of your health information. We may send notice directly to you or provide notice to the sponsor of your plan through which you receive coverage.

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. "Highly confidential information" may include confidential information under Federal laws governing alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information:

- HIV/AIDS;
- Mental health;
- Genetic tests;
- Alcohol and drug abuse;
- Sexually transmitted diseases and reproductive health information; and
- Child or adult abuse or neglect, including sexual assault.

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. Attached to this notice is a summary of federal and state laws on use and disclosure of certain types of medical information.

Except for uses and disclosures described and limited as set forth in this notice, we will use and disclose your health information only with a written authorization from you. Once you give us authorization to release your health information, we cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at anytime 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, contact the phone number listed on the back of your 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. We will accept verbal requests to receive confidential communications, but requests to modify 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 obtain a copy** of health information that may be used to make decisions about you such as claims and case or medical management records. You also may in some cases receive a summary of this health information. You must make a written request to inspect and copy your health information. We may charge a reasonable fee for any copies. If we deny your request, you have the right to have the denial reviewed. If we maintain an electronic health record containing your health information, when and if we are required by law, you will have the right to request that we send a copy of your health information in an electronic format to you or to a third party that you identify. We may charge a reasonable fee for sending the electronic copy of your health information.

- **You have the right to ask to amend** information we maintain about you 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) prior to April 14, 2003; (ii) for treatment, payment and health care operations purposes; (iii) to you or pursuant to your authorization; (iv) to correctional institutions or law enforcement officials; and (v) 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 obtain a copy of this notice at our website, www.myuhc.com.
Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want to exercise any of your rights, please call the toll-free phone number on the back of your ID card or you may contact the UnitedHealth Group Customer Call Center at 800-815-8958.

- **Submitting a Written Request.** Mail to us your written requests for modifying or cancelling a confidential communication, for copies of your records, or for amendments to your record, 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.
FINANCIAL INFORMATION PRIVACY NOTICE

This notice describes how financial information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means 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

We 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 consumer reports.

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.

For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities listed on the first page of the Health Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliates: AmeriChoice Health Services, Inc.; DBP Services of New York IPA, Inc.; DCG Resource Options, LLC; Dental Benefit Providers, Inc.; Dental Benefit Providers of California, Inc.; Dental Benefit Providers of Illinois, Inc.; Disability Consulting Group, LLC; HealthAllies, Inc.; MAMSI Insurance Resources, LLC; Managed Physical Network, Inc.; Mid Atlantic Medical Services, LLC; National Pacific Dental, Inc.; Nevada Pacific Dental; OneNet PPO, LLC; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; PacifiCare Health Plan Administrators, Inc.; ProcessWorks, Inc.;
Spectera, Inc.; Spectera of New York, IPA, Inc.; UMR, Inc.; Unimerica Insurance Company; Unimerica Life Insurance Company of New York; Unison Administrative Services, LLC; United Behavioral Health of New York IPA, Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Service LLC; UnitedHealthcare Services Company of the River Valley, Inc.; UnitedHealthOne Agency, 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.
Confidentiality and Security

We restrict access to personal financial information about you to our employees and service providers who are involved in administering your health care coverage and providing services to you. We maintain physical, electronic and procedural safeguards in compliance with state and federal standards to guard your personal financial information. We conduct regular audits to help ensure appropriate and secure handling and processing of our enrollees' information.

Questions about this Notice

If you have any questions about this notice, please call the toll-free phone number on the back of your ID card or you may contact the UnitedHealth Group Customer Call Center at 800-815-8958.
THE FIRST PART OF THIS NOTICE, WHICH PROVIDES OUR PRIVACY PRACTICES FOR MEDICAL INFORMATION, DESCRIBES HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION UNDER FEDERAL PRIVACY RULES. THERE ARE OTHER LAWS THAT MAY LIMIT OUR RIGHTS TO USE AND DISCLOSE YOUR HEALTH INFORMATION BEYOND WHAT WE ARE ALLOWED TO DO UNDER THE FEDERAL PRIVACY RULES. THE PURPOSE OF THE CHARTS BELOW IS TO:

- Show the categories of health information that are subject to these more restrictive laws.
- Give you a general summary of when we can use and disclose your health information without your consent.

If your written consent is required under the more restrictive laws, the consent must meet the particular rules of the applicable federal or state law.

### Summary of Federal Laws

<table>
<thead>
<tr>
<th>Alcohol &amp; Drug Abuse Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>We are allowed to use and disclose alcohol and drug abuse information that is protected by federal law only (1) in certain limited circumstances, and/or disclose only (2) to specific recipients.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Genetic Information</th>
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<tbody>
<tr>
<td>We are not allowed to use genetic information for underwriting purposes.</td>
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</tbody>
</table>

### Summary of State Laws

<table>
<thead>
<tr>
<th>General Health Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>We are allowed to disclose general health information only (1) under certain limited circumstances, and/or (2) to specific recipients.</td>
</tr>
<tr>
<td>HMOs must give enrollees an opportunity to approve or refuse disclosures, subject to certain exceptions.</td>
</tr>
<tr>
<td>You may be able to restrict certain electronic disclosures of health information.</td>
</tr>
<tr>
<td><strong>We are not allowed to use health information for certain purposes.</strong></td>
</tr>
<tr>
<td><strong>We will not use and/or disclose information regarding certain public assistance programs except for certain purposes.</strong></td>
</tr>
</tbody>
</table>

**Prescriptions**

| **We are allowed to disclose prescription-related information only (1) under certain limited circumstances, and/or (2) to specific recipients.** | ID, NH, NV |

**Communicable Diseases**

| **We are allowed to disclose communicable disease information only (1) under certain limited circumstances, and/or (2) to specific recipients.** | AZ, IN, KS, MI, NV, OK |

**Sexually Transmitted Diseases and Reproductive Health**

| **We are allowed to disclose sexually transmitted disease and/or reproductive health information only (1) under certain limited circumstances and/or (2) to specific recipients.** | CA, FL, HI, IN, KS, MI, MT, NJ, NV, PR, WA, WY |

**Alcohol and Drug Abuse**

| **We are allowed to use and disclose alcohol and drug abuse information (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.** | CT, GA, HI, KY, IL, IN, IA, LA, NC, NH, WA, WI |

**Disclosures of alcohol and drug abuse information may be restricted by the individual who is the subject of the information.** | WA |

**Genetic Information**

| **We are not allowed to disclose genetic information without your written consent.** | CA, CO, HI, IL, KS, KY, LA, NY, RI, TN, WY |

<p>| <strong>We are allowed to disclose genetic information only (1) under certain limited circumstances and/or (2) to specific recipients.</strong> | AK, AZ, FL, GA, IA, MD, MA, MO, NJ, NV, NH, NM, OR, RI, TX, UT, VT |</p>
<table>
<thead>
<tr>
<th>Restrictions apply to (1) the use, and/or (2) the retention of genetic information.</th>
<th>FL, GA, IA, LA, MD, NM, OH, UT, VA, VT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HIV / AIDS</strong></td>
<td></td>
</tr>
<tr>
<td>We are allowed to disclose HIV/AIDS-related information only (1) under certain limited circumstances and/or (2) to specific recipients.</td>
<td>AZ, AR, CA, CT, DE, FL, GA, HI, IA, IL, IN, KS, KY, ME, MI, MO, MT, NY, NC, NH, NM, NV, OR, PA, PR, RI, TX, VT, WV, WA, WI, WY</td>
</tr>
<tr>
<td>Certain restrictions apply to oral disclosures of HIV/AIDS-related information.</td>
<td>CT, FL</td>
</tr>
<tr>
<td><strong>Mental Health</strong></td>
<td></td>
</tr>
<tr>
<td>We are allowed to disclose mental health information only (1) under certain limited circumstances and/or (2) to specific recipients.</td>
<td>CA, CT, DC, HI, IA, IL, IN, KY, MA, MI, NC, NM, PR, TN, WA, WI</td>
</tr>
<tr>
<td>Disclosures may be restricted by the individual who is the subject of the information.</td>
<td>WA</td>
</tr>
<tr>
<td>Certain restrictions apply to oral disclosures of mental health information.</td>
<td>CT</td>
</tr>
<tr>
<td>Certain restrictions apply to the use of mental health information.</td>
<td>ME</td>
</tr>
<tr>
<td><strong>Child or Adult Abuse</strong></td>
<td></td>
</tr>
<tr>
<td>We are allowed to use and disclose child and/or adult abuse information only (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.</td>
<td>AL, CO, IL, LA, NE, NJ, NM, RI, TN, TX, UT, WI</td>
</tr>
</tbody>
</table>
ERISA


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

Continue Group Health Plan Coverage
You are entitled to continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. The Plan Sponsor is responsible for providing you notice of your COBRA continuation rights. Review the Summary Plan Description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

You are entitled to a reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another group health plan. You should be provided a certificate of creditable coverage, in writing, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. You may request a certificate of creditable coverage by calling the number on the back of your ID card. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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 obtain copies of documents relating to the decision without charge, and to appeal
any denial, all within certain time schedules. Under *ERISA*, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day 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 obtain certain publications about your rights and responsibilities under *ERISA* by calling the publication hotline of the *Employee Benefits Security Administration*.
ERISA Statement

If the Enrolling Group is subject to ERISA, the following information applies to you.

Summary Plan Description

Name of Plan: Educators Benefit Services, Inc. Welfare Benefit Plan

Name, Address and Telephone Number of Plan Sponsor and Named Fiduciary:

Educators Benefit Services, Inc.
890 Airport Park Rd
Suite 103
Glen Burnie, MD 21061
(410) 590-6548

The Plan Sponsor retains all fiduciary responsibilities with respect to the Plan except to the extent the Plan Sponsor has delegated or allocated to other persons or entities one or more fiduciary responsibility with respect to the Plan.

Claims Fiduciary:

Optimum Choice, Inc.

Employer Identification Number (EIN): 52-1642161

IRS Plan Number: 501

Effective Date of Plan: The effective date of the Plan or restatement of the Plan, whichever is later, is January 1, 2013.

Type of Plan: Health care coverage plan

Name, business address, and business telephone number of Plan Administrator:

Educators Benefit Services, Inc.
890 Airport Park Rd
Suite 103
Glen Burnie, MD 21061
(410) 590-6548

Type of Administration of the Plan:

Benefits are paid pursuant to the terms of a group health policy issued and insured by:

Optimum Choice, Inc.
4 Taft Court
Rockville, MD 20850

The Plan is administered on behalf of the Plan Administrator by Optimum Choice, Inc. pursuant to the group Policy.

Optimum Choice, Inc. provides administrative services for the Plan including claims processing, claims payment, and handling appeals.

Person designated as agent for service of legal process:

Plan Administrator: Educators Benefit Services, Inc.

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.

**Date of the end of the year for purposes of maintaining Plan's fiscal records:** Plan year shall be a 12 month period ending January 1.

**Determinations of 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.