UnitedHealthcare Choice Plus

Certificate of Coverage

For
the Choice Plus 100% Health Savings Account (HSA) Plan
of
AIMS Health Plan
Enrolling Group Number: 717578
Effective Date: January 1, 2017

Offered and Underwritten by
UnitedHealthcare Insurance Company
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We do not Pay Benefits for Exclusions

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C. Devices, Appliances and Prosthetics
D. Drugs
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ERISA Statement
UnitedHealthcare Choice Plus
UnitedHealthcare Insurance Company
Schedule of Benefits

Accessing Benefits
You can choose to receive Network Benefits or Non-Network Benefits.

Network Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider.

Non-Network Benefits apply to Covered Health Services that are provided by a non-Network Physician or other non-Network provider, or Covered Health Services that are provided at a non-Network facility.

Depending on the geographic area and the service you receive, you may have access through our Shared Savings Program to non-Network providers who have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from these providers, the Coinsurance will remain the same as it is when you receive Covered Health Services from non-Network providers who have not agreed to discount their charges; however, the total that you owe may be less when you receive Covered Health Services from Shared Savings Program providers than from other non-Network providers because the Eligible Expense may be a lesser amount.

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under a UnitedHealthcare Policy. As a result, they may bill you for the entire cost of the services you receive.

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

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

Prior Authorization
We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Network Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior authorization is required are identified below and in the Schedule of Benefits table within each Covered Health Service category.

We recommend that you confirm with us that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact us by calling the telephone number for Customer Care on your ID card.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when a non-Network provider intends to admit you to a Network facility or refers you to other Network providers. Once you have obtained
the authorization, please review it carefully so that you understand what services have been
authorized and what providers are authorized to deliver the services that are subject to the
authorization.

To obtain prior authorization, call the telephone number for Customer Care on your ID card. This
call starts the utilization review process.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the
clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings.
Such techniques may include ambulatory review, prospective review, second opinion, certification,
concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in
the Schedule of Benefits table to determine how far in advance you must obtain prior
authorization.

- Ambulance - non-emergency air and ground.
- Amino acid-based elemental formula.
- Clinical trials.
- Congenital heart disease surgery.
- Dental services - accidental.
- Durable Medical Equipment over $1,000 in cost (either retail purchase cost or cumulative retail
  rental cost of a single item).
- Genetic Testing - BRCA.
- Home health care.
- Hospice care - inpatient.
- Hospital inpatient care - all scheduled admissions and maternity stays exceeding 48 hours for
  uncomplicated vaginal delivery or 96 hours for an uncomplicated cesarean section delivery.
- Infertility services.
- In vitro fertilization.
- Lab, X-ray and diagnostics - sleep studies.
- Lab, X-ray and major diagnostics - CT, PET Scans, MRI, MRA, Nuclear Medicine and Capsule
  Endoscopy.
- Medical foods.
- Mental Health Services - inpatient services (including Partial Hospitalization/Day Treatment and
  services at a Residential Treatment Facility); Intensive Outpatient Treatment programs; outpatient
  electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45
  - 50 minutes in duration, with or without medication management.
- Neurobiological disorders - Autism Spectrum Disorder services - inpatient services (including
  Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility), Intensive
  Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond
  45 - 50 minutes in duration, with or without medication management.
- Obesity Surgery.
- Prosthetic devices over $1,000 in cost per device.
- Reconstructive procedures, including breast reconstruction surgery following mastectomy.
- Rehabilitation services and Manipulative Treatment - physical therapy, occupational therapy, Manipulative Treatment and speech therapy.
- Skilled Nursing Facility and Inpatient Rehabilitation Facility services.
- Substance Use Disorder Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.
- Surgery - only for the following outpatient surgeries: cardiac catheterization, pacemaker insertion, pain management procedures, implantable cardioverter defibrillators, diagnostic catheterization and electrophysiology implant and sleep apnea surgeries.
- Therapeutics - only for the following services: dialysis, intensity modulated radiation therapy and MR-guided focused ultrasound.
- Transplants.

For all other services, when you choose to receive services from non-Network providers, we urge you to confirm with us that the services you plan to receive are Covered Health Services. That's because in some instances, certain procedures may not be Medically Necessary or may not otherwise meet the definition of a Covered Health Service, and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

**Utilization Review Determinations**

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

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

Utilization review is provided to determine whether the requested service is a Covered Health Service. We do not make treatment decisions about the kind of care you should or should not receive. You and your provider must make those treatment decisions.

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

Initial utilization review Benefit determinations on whether to authorize or certify a non-emergency course of treatment will be made within two (2) working days after receipt of information necessary to make the determination.
Utilization review determinations to authorize or certify an extended stay in a health care facility or to provide additional health care service will be made within one (1) working day after receipt of necessary information.

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

When prior authorization is required for inpatient or Residential Crisis Services for the treatment of Mental Health or substance use disorders, determinations on whether or not to authorize or certify such services will be made within 2 hours after receipt of necessary information.

Prior authorization is not required for Emergency Health Services.

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

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

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

An adverse determination may not be rendered for admission to a Hospital for up to 72 hours, as determined to be Medically Necessary by the patient's treating physician when; a) the admission is an involuntary admission as described under Maryland insurance law and; b) the Hospital immediately provides notification of the admission and the reasons for admission.

If the provider is required to submit a treatment plan in order for utilization review to be conducted for Mental Health Services and Substance Use Disorder Services, the uniform treatment plan as provided under Maryland insurance law will be accepted or, if service was provided in another state, a treatment plan mandated by that state. Such treatment plan must be properly completed by the provider and submitted by electronic transfer.

Your Right to a Second Opinion with Regard to Hospital Utilization Review Decisions

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

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

When you seek prior authorization as required, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before we pay Benefits under the Policy), the prior authorization requirements do not apply to you. Since Medicare is the primary payer, we will pay as secondary payer as described in Section 7: Coordination of Benefits. You are not required to obtain authorization before receiving Covered Health Services.

Benefits

Annual Deductibles are calculated on a calendar year basis.

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

When Benefit limits apply, the limit stated refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

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

<table>
<thead>
<tr>
<th>Payment Term And Description</th>
<th>Amounts</th>
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<tbody>
<tr>
<td><strong>Annual Deductible</strong></td>
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<tr>
<td>The amount of Eligible Expenses you incur for Covered Health Services per year before you are eligible to receive Benefits. The Annual Deductible applies to Covered Health Services under the Policy as indicated in this Schedule of Benefits, including Covered Health Services provided under the Outpatient Prescription Drug Rider. Benefits for insulin and diabetic supplies under the Outpatient Prescription Drug Rider are not subject to payment of the Annual Deductible. The Annual Deductible for Network Benefits includes the amount you pay for both Network and Non-Network Benefits for outpatient prescription drugs provided under the Outpatient Prescription Drug Rider. Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. When a Covered Person was previously covered under a group policy that was replaced by the group Policy, any amount already applied to that annual deductible provision of the prior policy will apply to the Annual Deductible provision under the Policy. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the Schedule of Benefits.</td>
<td><strong>Network</strong> For single coverage, the Annual Deductible is $2,000 per Covered Person. If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is $4,000. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied. <strong>Non-Network</strong> For single coverage, the Annual Deductible is $2,500 per Covered Person. If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is $5,000. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.</td>
</tr>
</tbody>
</table>
Out-of-Pocket Maximum

The maximum you pay per year for the Annual Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this Schedule of Benefits, including Covered Health Services provided under the Outpatient Prescription Drug Rider. The Out-of-Pocket Maximum for Network Benefits includes the amount you pay for both Network and Non-Network Benefits for outpatient prescription drug products provided under the Outpatient Prescription Drug Rider.

Details about the way in which Eligible Expenses are determined appear at the end of the Schedule of Benefits table.

The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following:

- Any charges for non-Covered Health Services.
- The amount Benefits are reduced if you do not obtain prior authorization as required.
- Charges that exceed Eligible Expenses.
- Copayments or Coinsurance for any Covered Health Service identified in the Schedule of Benefits table that does not apply to the Out-of-Pocket Maximum.

Network

For single coverage, the Out-of-Pocket Maximum is $2,000 per Covered Person.

If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is $4,000.

The Out-of-Pocket Maximum includes the Annual Deductible.

Non-Network

For single coverage, the Out-of-Pocket Maximum is $3,500 per Covered Person.

If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is $6,000.

The Out-of-Pocket Maximum includes the Annual Deductible.

Copayment

Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service. Any dollar amount Copayment is payable directly to the provider of the Covered Health Service at the time of service. If the provider does not request payment of the Copayment at the time service is rendered or a supply provided, you need not pay the Copayment at that time, and the provider will bill you for the Copayment. You will never be denied Covered Health Services because of an inability to meet the Copayment requirement.

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

- The applicable Copayment.
- The Eligible Expense.

Details about the way in which Eligible Expenses are determined appear at the end of the Schedule of Benefits table.
<table>
<thead>
<tr>
<th>Payment Term And Description</th>
<th>Amounts</th>
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<tbody>
<tr>
<td>Coinsurance</td>
<td></td>
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</table>

Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services.

Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.
When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

<table>
<thead>
<tr>
<th>Covered Health Service</th>
<th>Benefit (The Amount We Pay, based on Eligible Expenses)</th>
<th>Apply to the Out-of-Pocket Maximum?</th>
<th>Must You Meet Annual Deductible?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Acupuncture Services</td>
<td>Network&lt;br&gt;100%&lt;br&gt;Non-Network&lt;br&gt;80%</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>2. Ambulance Services</td>
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<td></td>
<td>Prior Authorization Requirement</td>
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<td></td>
<td>In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.</td>
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<tr>
<td>Emergency Ambulance</td>
<td>Network&lt;br&gt;GroundAmbulance:&lt;br&gt;100%&lt;br&gt;Air Ambulance:&lt;br&gt;100%&lt;br&gt;Non-Network Same as Network</td>
<td>No</td>
<td>Yes</td>
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<tr>
<td>Non-Emergency Ambulance</td>
<td>Non-Network Same as Network</td>
<td>Same as Network</td>
<td>Same as Network</td>
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<tr>
<td>3. Congenital Heart Disease Surgeries</td>
<td>Network&lt;br&gt;Ground Ambulance:&lt;br&gt;100%&lt;br&gt;Air Ambulance:&lt;br&gt;100%&lt;br&gt;Non-Network Same as Network</td>
<td>No</td>
<td>Yes</td>
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Prior Authorization Requirement
**When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.**

<table>
<thead>
<tr>
<th>Covered Health Service</th>
<th>Benefit (The Amount We Pay, based on Eligible Expenses)</th>
<th>Apply to the Out-of-Pocket Maximum?</th>
<th>Must You Meet Annual Deductible?</th>
</tr>
</thead>
<tbody>
<tr>
<td>For Non-Network Benefits you must obtain prior authorization as soon as the possibility of a congenital heart disease (CHD) surgery arises. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.</td>
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<tr>
<td>Network and Non-Network Benefits under this section include only the inpatient facility charges for the congenital heart disease (CHD) surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.</td>
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</tr>
<tr>
<td>Network</td>
<td>100%</td>
<td>No</td>
<td>Yes</td>
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<tr>
<td>Non-Network</td>
<td>80%</td>
<td>Yes</td>
<td>Yes</td>
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</tbody>
</table>

### 4. Dental Services - Accident Only

**Prior Authorization Requirement**

For Network and Non-Network Benefits you must obtain prior authorization five business days before follow-up (post-Emergency) treatment begins. (You do not have to obtain prior authorization before the initial Emergency treatment.) If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

<table>
<thead>
<tr>
<th>Network</th>
<th>100%</th>
<th>No</th>
<th>Yes</th>
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<tbody>
<tr>
<td>Non-Network</td>
<td>Same as Network</td>
<td>Same as Network</td>
<td>Same as Network</td>
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</tbody>
</table>

### 5. Diabetes Services

**Prior Authorization Requirement**

For Non-Network Benefits you must obtain prior authorization before obtaining any Durable Medical Equipment for the management and treatment of diabetes that exceeds $1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.

<table>
<thead>
<tr>
<th>Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care</th>
<th>Network</th>
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<tbody>
<tr>
<td>Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same</td>
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</table>
When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

<table>
<thead>
<tr>
<th>Covered Health Service</th>
<th>Benefit (The Amount We Pay, based on Eligible Expenses)</th>
<th>Apply to the Out-of-Pocket Maximum?</th>
<th>Must You Meet Annual Deductible?</th>
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<tbody>
<tr>
<td></td>
<td>as those stated under each Covered Health Service category in this Schedule of Benefits, except that any limit on the amount or duration of Benefits specific to such Covered Health Service category does not apply to Benefits for diabetes self-management items under this Covered Health Service. Non-Network</td>
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<tr>
<td><strong>Diabetes Self-Management Items</strong></td>
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<tr>
<td><strong>Network</strong></td>
<td>Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this Schedule of Benefits, except that any limit on the amount or duration of Benefits specific to such Covered Health Service category does not apply to Benefits for diabetes self-management items under this Covered Health Service.</td>
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<tr>
<td><strong>Non-Network</strong></td>
<td>Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under Durable Medical Equipment and in the Outpatient Prescription Drug Rider, except that any limit on the amount or duration of Benefits specific to the Durable Medical Equipment Benefit category or the Outpatient Prescription Drug Rider does not apply to Benefits for diabetes self-management items under this Covered Health Service.</td>
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<tr>
<td>6. Durable Medical Equipment</td>
<td>Prior Authorization Requirement</td>
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<tr>
<td></td>
<td>For Non-Network Benefits you must obtain prior authorization before obtaining any Durable Medical Equipment that exceeds $1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.</td>
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</tbody>
</table>
When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

<table>
<thead>
<tr>
<th>Covered Health Service</th>
<th>Benefit (The Amount We Pay, based on Eligible Expenses)</th>
<th>Apply to the Out-of-Pocket Maximum?</th>
<th>Must You Meet Annual Deductible?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefits are limited to a single purchase of a type of DME (including repair/replacement) every three years. This limit does not apply to wound vacuums, which are limited to a single purchase (including repair/replacement) every three years. To receive Network Benefits, you must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.</td>
<td><strong>Network</strong>&lt;br&gt;100%&lt;br&gt;No</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>&lt;br&gt;<strong>Non-Network</strong>&lt;br&gt;80%&lt;br&gt;Yes</td>
<td>Yes</td>
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</table>

7. Emergency Health Services - Outpatient

**Note:** If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify us within one business day or on the same day of admission if reasonably possible. We may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the non-Network Hospital after the date we decide a transfer is medically appropriate, Network Benefits will not be provided. Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service.

| Network | 100% | No | Yes |
| Non-Network | Same as Network | Same as Network | Same as Network |

8. Hearing Aids

Benefits for all Covered Persons are further limited to a single purchase (including repair/replacement) per

| Network | | | |

SBN.ACA15.CHP.I.11.MD 11
When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

<table>
<thead>
<tr>
<th>Covered Health Service</th>
<th>Benefit (The Amount We Pay, based on Eligible Expenses)</th>
<th>Apply to the Out-of-Pocket Maximum?</th>
<th>Must You Meet Annual Deductible?</th>
</tr>
</thead>
<tbody>
<tr>
<td>hearing impaired ear every three years.</td>
<td>100%</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Non-Network</td>
<td>80%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

9. Home Health Care

Prior Authorization Requirement

For Non-Network Benefits you must obtain prior authorization five business days before receiving services or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Limited to 200 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not apply to the visits mandated by state law described in Section 1: Covered Health Services of the Certificate of Coverage under Home Health Care.

<table>
<thead>
<tr>
<th></th>
<th>Network</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-Network</td>
<td>80%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

10. Hospice Care

Prior Authorization Requirement

For Non-Network Benefits you must obtain prior authorization five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

In addition, for Non-Network Benefits, you must contact us within 24 hours of admission for an Inpatient Stay in a hospice facility.

<table>
<thead>
<tr>
<th></th>
<th>Network</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-Network</td>
<td>80%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

11. Hospital - Inpatient Stay

Prior Authorization Requirement
When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

<table>
<thead>
<tr>
<th>Covered Health Service</th>
<th>Benefit (The Amount We Pay, based on Eligible Expenses)</th>
<th>Apply to the Out-of-Pocket Maximum?</th>
<th>Must You Meet Annual Deductible?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

For Non-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

<table>
<thead>
<tr>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

12. Infertility Services

Prior Authorization Requirement

You must obtain prior authorization as soon as possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

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

<table>
<thead>
<tr>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

13. Lab, X-Ray and Diagnostics - Outpatient

Prior Authorization Requirement

For Non-Network Benefits for sleep studies, you must obtain prior authorization five business days before scheduled services are received. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Lab Testing - Outpatient:

<table>
<thead>
<tr>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

<table>
<thead>
<tr>
<th>Covered Health Service</th>
<th>Benefit (The Amount We Pay, based on Eligible Expenses)</th>
<th>Apply to the Out-of-Pocket Maximum?</th>
<th>Must You Meet Annual Deductible?</th>
</tr>
</thead>
<tbody>
<tr>
<td>X-Ray and Other Diagnostic Testing - Outpatient:</td>
<td><strong>Network</strong></td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Non-Network</strong></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>14. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Prior Authorization Requirement**

For Non-Network Benefits you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Benefit</th>
<th>Apply to the Out-of-Pocket Maximum?</th>
<th>Must You Meet Annual Deductible?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Network</strong></td>
<td>100%</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Non-Network</strong></td>
<td>80%</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

15. Mental Health Services

**Prior Authorization Requirement**

For Non-Network Benefits for a scheduled admission for Mental Health Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

In addition, for Non-Network Benefits you must obtain prior authorization before the following services are received. Services requiring prior authorization: Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.

If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Benefit</th>
<th>Apply to the Out-of-Pocket Maximum?</th>
<th>Must You Meet Annual Deductible?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Network</strong></td>
<td>Inpatient</td>
<td>100%</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Outpatient</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

<table>
<thead>
<tr>
<th>Covered Health Service</th>
<th>Benefit (The Amount We Pay, based on Eligible Expenses)</th>
<th>Apply to the Out-of-Pocket Maximum?</th>
<th>Must You Meet Annual Deductible?</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>No</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>100% for Partial Hospitalization/Intensive Outpatient Treatment and all other outpatient services except office visits</td>
<td>No</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Non-Network</td>
<td>Inpatient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>80%</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Outpatient</td>
<td>80%</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>80% for Partial Hospitalization/Intensive Outpatient Treatment and all other outpatient services except office visits</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

16. Neurobiological Disorders - Autism Spectrum Disorder Services

Prior Authorization Requirement

For Non-Network Benefits for a scheduled admission for Neurobiological Disorders - Autism Spectrum Disorder Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

In addition, for Non-Network Benefits you must obtain prior authorization before the following services are received. Services requiring prior authorization: Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.

If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

<table>
<thead>
<tr>
<th>Network</th>
<th>Inpatient</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>No</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>
When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

<table>
<thead>
<tr>
<th>Covered Health Service</th>
<th>Benefit (The Amount We Pay, based on Eligible Expenses)</th>
<th>Apply to the Out-of-Pocket Maximum?</th>
<th>Must You Meet Annual Deductible?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Outpatient</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>100% for Partial Hospitalization/Intensive Outpatient Treatment and all other outpatient services except office visits</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td><em>Non-Network</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><em>Inpatient</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>80%</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td><em>Outpatient</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>80%</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>80% for Partial Hospitalization/Intensive Outpatient Treatment and all other outpatient services except office visits</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

17. Ostomy Supplies

Limited to $7,500 per year.

|                        | *Network*                                              |                                    |                                 |
|                        | 100%                                                   | No                                 | Yes                             |
|                        | *Non-Network*                                          |                                    |                                 |
|                        | 80%                                                    | Yes                                | Yes                             |

18. Pharmaceutical Products - Outpatient

|                        | *Network*                                              |                                    |                                 |
|                        | 100%                                                   | No                                 | Yes                             |
|                        | *Non-Network*                                          |                                    |                                 |
|                        | 80%                                                    | Yes                                | Yes                             |
When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

<table>
<thead>
<tr>
<th>Covered Health Service</th>
<th>Benefit <em>(The Amount We Pay, based on Eligible Expenses)</em></th>
<th>Apply to the Out-of-Pocket Maximum?</th>
<th>Must You Meet Annual Deductible?</th>
</tr>
</thead>
<tbody>
<tr>
<td>19. Physician Fees for Surgical and Medical Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Network</td>
<td>100%</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Non-Network</td>
<td>80%</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Prior Authorization Requirement

For Non-Network Benefits you must obtain prior authorization as soon as is reasonably possible before Genetic Testing - BRCA is performed. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

| 20. Physician’s Office Services - Sickness and Injury | | | |
| Network                | 100%                                                     | No                                 | Yes                             |
| Non-Network            | 80%                                                      | Yes                                | Yes                             |

Prior Authorization Requirement

For Non-Network Benefits you must obtain prior authorization as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following an uncomplicated vaginal delivery, or more than 96 hours for the mother and newborn child following an uncomplicated cesarean section delivery. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.

| 21. Pregnancy - Maternity Services | | | |
| Network                | Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits except that an Annual Deductible will not apply for a newborn child | | |
When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

<table>
<thead>
<tr>
<th>Covered Health Service</th>
<th>Benefit (The Amount We Pay, based on Eligible Expenses)</th>
<th>Apply to the Out-of-Pocket Maximum?</th>
<th>Must You Meet Annual Deductible?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>whose length of stay in the Hospital is the same as the mother's length of stay. <strong>Non-Network</strong> Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

22. Preventive Care Services

<table>
<thead>
<tr>
<th>Physician office services</th>
<th>Network</th>
<th>Non-Network</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>100%</td>
<td>No</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Lab, X-ray or other preventive tests</td>
<td>Network</td>
<td>Non-Network</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>No</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Breast pumps</td>
<td>Network</td>
<td>Non-Network</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>Yes</td>
<td>Yes, except for mammography screening</td>
<td></td>
</tr>
<tr>
<td></td>
<td>80%</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

23. Prosthetic Devices

**Prior Authorization Requirement**

For Non-Network Benefits you must obtain prior authorization before obtaining prosthetic devices that exceed $1,000 in cost per device. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Any limit below does not apply to prosthetic devices for any arm, leg, hand, foot, or eye as required under Maryland insurance law.

<table>
<thead>
<tr>
<th>Network</th>
<th>Non-Network</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>
When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

<table>
<thead>
<tr>
<th>Covered Health Service</th>
<th>Benefit (The Amount We Pay, based on Eligible Expenses)</th>
<th>Apply to the Out-of-Pocket Maximum?</th>
<th>Must You Meet Annual Deductible?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefits are limited to a single purchase of each type of prosthetic device every three years. Once this limit is reached, Benefits continue to be available for items required by the Women's Health and Cancer Rights Act of 1998.</td>
<td>Non-Network 80%</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

24. Reconstructive Procedures

**Prior Authorization Requirement**

For Non-Network Benefits you must obtain prior authorization five business days before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled inpatient admissions or as soon as is reasonably possible for non-scheduled inpatient admissions (including Emergency admissions).

**Network**

Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits, except that any limit on the amount or duration of Benefits specific to such Covered Health Service category does not apply to Benefits for reconstructive breast surgery under this Covered Health Service.

**Non-Network**

Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits, except that any limit on the amount or duration of Benefits specific to such Covered Health Service category does not apply to Benefits for reconstructive breast surgery under this Covered Health Service.

25. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment
When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

<table>
<thead>
<tr>
<th>Covered Health Service</th>
<th>Benefit (The Amount We Pay, based on Eligible Expenses)</th>
<th>Apply to the Out-of-Pocket Maximum?</th>
<th>Must You Meet Annual Deductible?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prior Authorization Requirement</strong></td>
<td>For Non-Network Benefits you must obtain prior authorization five business days before receiving physical therapy, occupational therapy, Manipulative Treatment and speech therapy or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limited per year as follows:</td>
<td>Network</td>
<td>100%</td>
<td>No</td>
</tr>
<tr>
<td>• 60 visits of physical therapy.</td>
<td>Non-Network</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>• 60 visits of occupational therapy.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 60 Manipulative Treatments.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 60 visits of speech therapy.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 60 visits of pulmonary rehabilitation therapy.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 36 visits of cardiac rehabilitation therapy.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 30 visits of post-cochlear implant aural therapy.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 20 visits of cognitive rehabilitation therapy.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Note: Outpatient rehabilitative services received in connection with the Treatment of Cleft Lip or Palate or Both Benefit shown below under Additional Benefits Required by Maryland Law, are not subject to any limit shown above.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>26. Scopic Procedures - Outpatient Diagnostic and Therapeutic</strong></td>
<td>Network</td>
<td>100%</td>
<td>No</td>
</tr>
</tbody>
</table>
When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

<table>
<thead>
<tr>
<th>Covered Health Service</th>
<th>Benefit (The Amount We Pay, based on Eligible Expenses)</th>
<th>Apply to the Out-of-Pocket Maximum?</th>
<th>Must You Meet Annual Deductible?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Non-Network</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>80%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>27. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Prior Authorization Requirement

For Non-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

Limited to 180 days per year.

<table>
<thead>
<tr>
<th></th>
<th>Network</th>
<th>Non-Network</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>100%</td>
<td>80%</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>28. Substance Use Disorder Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Prior Authorization Requirement

For Non-Network Benefits for a scheduled admission for Substance Use Disorder Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

In addition, for Non-Network Benefits you must obtain prior authorization before the following services are received. Services requiring prior authorization: Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.

If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

<table>
<thead>
<tr>
<th></th>
<th>Network</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Inpatient</td>
<td>100%</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Outpatient</td>
<td>100%</td>
<td>No</td>
</tr>
</tbody>
</table>
When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

<table>
<thead>
<tr>
<th>Covered Health Service</th>
<th>Benefit <em>(The Amount We Pay, based on Eligible Expenses)</em></th>
<th>Apply to the Out-of-Pocket Maximum?</th>
<th>Must You Meet Annual Deductible?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>100% for Partial Hospitalization/Intensive Outpatient Treatment and all other outpatient services except office visits</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Non-Network</strong></td>
<td></td>
<td></td>
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<tr>
<td><em>Inpatient</em></td>
<td></td>
<td></td>
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<tr>
<td>80%</td>
<td></td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td><em>Outpatient</em></td>
<td></td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>80%</td>
<td></td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>80% for Partial Hospitalization/Intensive Outpatient Treatment and all other outpatient services except office visits</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**29. Surgery - Outpatient**

**Prior Authorization Requirement**

For Non-Network Benefits for cardiac catheterization, pacemaker insertion, pain management procedures, implantable cardioverter defibrillators, diagnostic catheterization and electrophysiology implant and sleep apnea surgery you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

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<thead>
<tr>
<th>Network</th>
<th>Non-Network</th>
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</thead>
<tbody>
<tr>
<td>100%</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Non-Network</strong></td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**30. Therapeutic Treatments - Outpatient**

**Prior Authorization Requirement**

For Non-Network Benefits you must obtain prior authorization for the following outpatient therapeutic services five business days before scheduled services are received or, for non-scheduled services,
When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

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<tr>
<th>Covered Health Service</th>
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<tr>
<td></td>
<td></td>
<td>within one business day or as soon as is reasonably possible. Services that require prior authorization: dialysis, intensity modulated radiation therapy and MR-guided focused ultrasound. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.</td>
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<td></td>
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<tr>
<td></td>
<td>80%</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

31. Transplantation Services

**Prior Authorization Requirement**

For Network Benefits you must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Network Benefits will not be paid. Non-Network Benefits will apply.

For Non-Network Benefits you must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

For Network Benefits, transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility in order for you to receive Network Benefits.

**Network**

Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.

**Non-Network**

Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.

32. Urgent Care Center Services

<table>
<thead>
<tr>
<th>Network</th>
<th>100%</th>
<th>No</th>
<th>Yes</th>
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<tr>
<td>Non-Network</td>
<td>80%</td>
<td>Yes</td>
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</tr>
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</table>

Additional Benefits Required By Maryland Law

33. Amino Acid-Based Elemental Formula  

Prior Authorization Requirement  
For Non-Network Benefits you must obtain prior authorization before obtaining any amino acid-based elemental formula. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

<table>
<thead>
<tr>
<th>Network</th>
<th>100%</th>
<th>No</th>
<th>Yes</th>
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</thead>
<tbody>
<tr>
<td>Non-Network</td>
<td>80%</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

34. Bones of Face, Neck, and Head  

Prior Authorization Requirement  
Depending upon where the Covered Health Service is provided, any applicable authorization requirements will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.

Network  
Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits except that any limit on the amount or duration of Benefits specific to such Covered Health Service category does not apply to Benefits under this Covered Health Service.

Non-Network  
Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits except that any limit on the amount or duration of Benefits specific to such Covered Health Service category does not apply to Benefits under this Covered Health Service.
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</thead>
</table>

### 35. Child Wellness Services

**Prior Authorization Requirement**

Depending upon where the Covered Health Service is provided, any applicable authorization requirements will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.

**Network**

Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that no deductible applies to these services and any limit on the amount or duration of Benefits specific to such Covered Health Service category does not apply to Benefits under this Covered Health Service.

**Non-Network**

Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that no deductible applies to these services and any limit on the amount or duration of Benefits specific to such Covered Health Service category does not apply to Benefits under this Covered Health Service.

### 36. Treatment of Cleft Lip or Palate or Both

**Prior Authorization Requirement**

Depending upon where the Covered Health Service is provided, any applicable authorization requirements will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.

**Network**

Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that any limit on the amount or duration of Benefits specific to such Covered Health Service category does not apply to Benefits under this Covered Health Service.

**Non-Network**

Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that any limit on the amount or duration of Benefits specific to such Covered Health Service category does not apply to Benefits under this Covered Health Service.
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<tr>
<td>Benefits except that any limit on the amount or duration of Benefits specific to such Covered Health Service category does not apply to Benefits under this Covered Health Service.</td>
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</table>

37. Clinical Trials

Prior Authorization Requirement

You must obtain prior authorization as soon as reasonably possible after the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.

Network

Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits except that any limit on the amount or duration of Benefits specific to such Covered Health Service category does not apply to Benefits under this Covered Health Service.

Non-Network

Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits except that any limit on the amount or duration of Benefits specific to such Covered Health Service category does not apply to Benefits under this Covered Health Service.

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

Prior Authorization Requirement

Depending upon where the Covered Health Service is provided, any applicable authorization requirements will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.

Network

Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits except that any limit on the amount or duration of Benefits specific to such Covered Health Service category does not apply to Benefits under this Covered Health Service.

Non-Network

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39. Habilitative Services

Prior Authorization Requirement

Depending upon where the Covered Health Service is provided, any applicable authorization requirements will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.

Network

Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits except that any limit on the amount or duration of Benefits specific to such Covered Health Service category does not apply to Benefits under this Covered Health Service.

Non-Network

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40. Hair Prosthesis

Limited to $350 per year.

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<th></th>
<th>Network</th>
<th>Non-Network</th>
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<tbody>
<tr>
<td></td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>80%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

41. In Vitro Fertilization

Prior Authorization Requirement

You must obtain prior authorization as soon as reasonably possible after the need for in vitro fertilization services arises. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Limited to three in vitro fertilization attempts per live birth, subject to a

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Depending upon where the Covered Health Service is
When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

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</thead>
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<tr>
<td>maximum Benefit of $100,000 per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy. This limit includes Benefits for infertility medications provided under the Outpatient Prescription Drug Rider. provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits except that any limit on the amount or duration of Benefits specific to such Covered Health Service category does not apply to Benefits under this Covered Health Service.</td>
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</table>

**Non-Network**

Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits except that any limit on the amount or duration of Benefits specific to such Covered Health Service category does not apply to Benefits under this Covered Health Service.

### 42. Medical Foods

**Prior Authorization Requirement**

For Non-Network Benefits you must obtain prior authorization before obtaining any medical foods. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

<table>
<thead>
<tr>
<th>Network</th>
<th>Non-Network</th>
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</thead>
<tbody>
<tr>
<td>100%</td>
<td>Yes</td>
<td></td>
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<tr>
<td>80%</td>
<td>Yes</td>
<td></td>
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</table>

### 43. Surgical Morbid Obesity Treatment

**Prior Authorization Requirement**

You must obtain prior authorization as soon as the possibility of obesity surgery arises. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

It is important that you notify us regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.

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<th>Network</th>
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</table>
When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Benefits specific to such Covered Health Service category does not apply to Benefits under this Covered Health Service. <strong>Non-Network</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits except that any limit on the amount or duration of Benefits specific to such Covered Health Service category does not apply to Benefits under this Covered Health Service.</td>
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<tr>
<td>44. Telemedicine Services</td>
<td><strong>Network</strong></td>
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<td></td>
<td>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.</td>
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<tr>
<td></td>
<td><strong>Non-Network</strong></td>
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</table>

**Eligible Expenses**

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount we will pay for Eligible Expenses, except that this provision does not apply to Benefits received due to services provided by on-call Physicians, Hospital-based Physicians, or ambulance service providers as defined under Maryland law, who have accepted an assignment of Benefits. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the Certificate.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.

- When Covered Health Services are received from a non-Network provider as a result of an Emergency or as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Non-Network Benefits, Eligible Expenses are based on either of the following:
When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on:

- Negotiated rates agreed to by the non-Network provider and either us or one of our vendors, affiliates or subcontractors, at our discretion.

- If rates have not been negotiated, then one of the following amounts:
  - Eligible Expenses are determined based on 140% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market, with the exception of the following:
    - 50% of CMS for the same or similar laboratory service.
    - 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.
  - When a rate is not published by CMS for the service, we use an available gap methodology to determine a rate for the service as follows:
    - For services other than Pharmaceutical Products, we use a gap methodology established by OptumInsight and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale(s) currently in use become no longer available, we will use a comparable scale(s). We and OptumInsight are related companies through common ownership by UnitedHealth Group. Refer to our website at www.myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information.
    - For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by RJ Health Systems, Thomson Reuters (published in its Red Book), or UnitedHealthcare based on an internally developed pharmaceutical pricing resource.
    - When a rate is not published by CMS for the service and a gap methodology does not apply to the service, the Eligible Expense is based on 50% of the provider's billed charge.

We update the CMS published rate data on a regular basis when updated data from CMS becomes available. These updates are typically implemented within 30 to 90 days after CMS updates its data.

However, Eligible Expenses for a Covered Health Service received from a from a non-Network provider will never be less than Eligible Expenses for that same Covered Health Service if that Covered Health Service had been received from a Network provider in the same geographic area.

**IMPORTANT NOTICE:** Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

The following provision applies to on-call Physicians or Hospital-based Physicians who are:

- Non-Network providers;
- Have obtained an assignment of Benefits; and
Who have notified us in a manner specified by the Insurance Commissioner that they have obtained and accepted an assignment of Benefits.

Payment for a claim submitted by an on-call Physician for a Covered Health Service rendered to a Covered Person in a Hospital will be no less than the greater of:

- 140% of the average rate we paid for the 12-month period that ends on January 1 of the previous calendar year in the same geographic area, as defined by the Centers for Medicare and Medicaid Services, for the same Covered Health Service, to similarly licensed Network providers; or

- The average rate we paid for the 12-month period that ended on January 1, 2010, in the same geographic area, as defined by the Centers for Medicare and Medicaid Services, for the same Covered Health Service to a similarly licensed non-Network provider, inflated by the change in the Medicare Economic Index from 2010 to the current year.

Payment for a claim submitted by a Hospital-based Physician for a Covered Health Service rendered to a Covered Person will be no less than the greater of:

- 140% of the average rate we paid for the 12-month period that ends on January 1 of the previous calendar year in the same geographic area, as defined by the Centers for Medicare and Medicaid Services, for the same Covered Health Service, to similarly licensed providers, who are Network Hospital-based Physicians; or

- Our final Eligible Expense for the same Covered Health Service for the 12-month period that ended on January 1, 2010, inflated by the change in the Medicare Economic Index to the current year, to the Hospital-based Physician billing under the same federal tax identification number the Hospital-based Physician used in calendar year 2009.

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.

**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.

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 Care. A directory of providers is available online at www.myuhc.com or by calling Customer Care at the telephone number on your ID card to request a copy.

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

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact Customer Care at the telephone number on your ID card.

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.
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.

**Designated Facilities and Other Providers**

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses at our discretion.

In both cases, Network Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Network Benefits will not be paid. Non-Network Benefits may be available if the special needs services you receive are Covered Health Services for which Benefits are provided under the Policy.

**Health Services from Non-Network Providers Paid as Network Benefits**

If you are diagnosed with a condition or disease that requires specialized health care services or medical care and such specialized service or care is either not available from a Network provider or access to such a Network provider would require unreasonable delay or travel, you may be eligible for Network Benefits when Covered Health Services are received from non-Network providers. In this situation, you may request a referral to a non-Network provider from your Network Physician who will notify us and, if we confirm that the required specialized service or care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

**Limitations on Selection of Providers**

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

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

If you fail to use the selected Network Physician, Covered Health Services will be paid as Non-Network Benefits.

**Continuity of Care**

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

- The procedures, treatments, medications or services that are Covered Health Services under this Policy for the following periods of time:
  - The lesser of the course of treatment or 90 days; and
  - The duration of the three trimesters of a Pregnancy and the initial postpartum visit.
Upon transition from your prior carrier coverage to this Policy, we will allow you to continue prior carrier health care services when they are Covered Health Services under this Policy provided by a non-Network provider for the following conditions:

- Acute conditions;
- Serious chronic conditions;
- Pregnancy;
- Mental Health Services and Substance Use Disorder Services; and
- Any other condition for which the non-Network provider and us reach agreement.

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

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

We will pay a non-Network provider under this provision in accordance with all the applicable requirements of rates and methods of payment under Maryland and federal law. However, the non-Network provider has the option to decline the rate and method of payment by providing a 10 day notice to the Covered Person and to us. In this event, we may reach an agreement with the non-Network provider on an alternative rate for the payment of Covered Health Services. If an agreement for an alternative rate or method of payment is not reached, the non-Network provider is not required to continue to provide services.
Certificate of Coverage

UnitedHealthcare Insurance Company

Certificate of Coverage is Part of Policy

This Certificate of Coverage (Certificate) is part of the Policy that is a legal document between UnitedHealthcare Insurance Company 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 Group Policy.
- The Schedule of Benefits.
- The Enrolling Group's application.
- Riders, including the Outpatient Prescription Drug Rider.
- Amendments.

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 this Certificate. When that happens we will send you a new Certificate, Rider or Amendment pages.

A change in the Policy is not valid:

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

Other Information You Should Have

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 in the time zone of the Enrolling Group's location. 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.
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 the attached Schedule of Benefits along with Section 1: Covered Health Services and Section 2: Exclusions and Limitations. You should also carefully read Section 8: 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 coverage available to you.

Many of the sections of this 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 Schedule of Benefits and any attachments in a safe place for your future reference.

If there is a conflict between this Certificate and any summaries provided to you by the Enrolling Group, this Certificate will control.

Please be aware that your Physician 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 9: Defined Terms. You can refer to Section 9: Defined Terms 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 UnitedHealthcare Insurance Company. When we use the words "you" and "your," we are referring to people who are Covered Persons, as that term is defined in Section 9: Defined Terms.

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 Care listed on your ID card. It will be our pleasure to assist you.
Your Responsibilities

Be Enrolled and Pay Required Contributions

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

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

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

Be Aware this Benefit Plan Does Not Pay for All Health Services

Your right to Benefits is limited to Covered Health Services. The extent of this Benefit plan's payments for Covered Health Services and any obligation that you may have to pay for a portion of the cost of those Covered Health Services is set forth in the Schedule of Benefits.

Decide What Services You Should Receive

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

Choose Your Physician

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

Obtain Prior Authorization

Some Covered Health Services require prior authorization. In general, Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. However, if you choose to receive Covered Health Services from a non-Network provider, you are responsible for obtaining prior authorization before you receive the services. For detailed information on the Covered Health Services that require prior authorization, please refer to the Schedule of Benefits.

Pay Your Share

You must meet any applicable deductible and pay a Copayment and/or Coinsurance for most Covered Health Services. These payments are due at the time of service or when billed by the Physician, provider or facility. Any applicable deductible, Copayment and Coinsurance amounts are listed in the Schedule of Benefits. You must also pay any amount that exceeds Eligible Expenses.
Pay the Cost of Excluded Services
You must pay the cost of all excluded services and items. Review Section 2: Exclusions and Limitations to become familiar with this Benefit plan's exclusions.

Show Your ID Card
You should show your identification (ID) card every time you request health services. If you do not show your ID card, the provider may fail to bill the correct entity for the services delivered, and any resulting delay may mean that you will be unable to collect any Benefits otherwise owed to you.

File Claims with Complete and Accurate Information
When you receive Covered Health Services from a non-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described in Section 5: How to File a Claim.
Our Responsibilities

Determine Benefits

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

We have the discretion to do the following:

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

We may delegate this discretionary authority to other persons or entities that may provide administrative services for this Benefit plan, such as claims processing. The identity of the service providers and the nature of their services may be changed from time to time in our discretion. In order to receive Benefits, you must cooperate with those service providers.

Pay for Our Portion of the Cost of Covered Health Services

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

Pay Network Providers

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

Pay for Covered Health Services Provided by Non-Network Providers

In accordance with any state prompt pay requirements, we will pay Benefits after we receive your request for payment that includes all required information. See Section 5: How to File a Claim.

Review and Determine Benefits in Accordance with our Reimbursement Policies

We develop our reimbursement policy guidelines, in our sole discretion, in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS).
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that we accept.
Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), our reimbursement policies are applied to provider billings. We share our reimbursement policies with Physicians and other providers in our Network through our provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. However, non-Network providers are not subject to this prohibition, and may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed, however this provision does not apply to an on-call Physician, a Hospital-based Physician, or an ambulance service provider as defined under Maryland law, who has accepted an assignment of Benefits. An on-call Physician, Hospital-based Physician, or ambulance service provider as defined under Maryland law, who has accepted an assignment of Benefits will be paid in accordance with the payment methodology as required in Maryland law. You may obtain copies of our reimbursement policies for yourself or to share with your non-Network Physician or provider by going to www.myuhc.com or by calling Customer Care at the telephone number on your ID card.

Offer Health Education Services to You

From time to time, we may provide you with access to information about additional services that are available to you, such as disease management programs, health education and patient advocacy. It is solely your decision whether to participate in the programs, but we recommend that you discuss them with your Physician.
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Section 1: Covered Health Services

Benefits for Covered Health Services

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

- The health care service, supply or Pharmaceutical Product is only a Covered Health Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Service in Section 9: Defined Terms.) The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Service under the Policy.

- Covered Health Services are received while the Policy is in effect or are provided to Covered Persons under the Extension of Coverage provision in Section 4: When Coverage Ends.

- Covered Health Services are received prior to the date that any of the individual termination conditions listed in Section 4: When Coverage Ends occurs or are provided to Covered Persons under the Extension of Coverage provision in Section 4: When Coverage Ends.

- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements specified in the Policy or is receiving Benefits under the Extension of Coverage provision in Section 4: When Coverage Ends.

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

- The amount you must pay for these Covered Health Services (including any Annual Deductible, Copayment and/or Coinsurance).

- Any limit that applies to these Covered Health Services (including visit, day and dollar limits on services).

- Any limit that applies to the amount of Eligible Expenses you are required to pay in a year (Out-of-Pocket Maximum).

- Any responsibility you have for obtaining prior authorization or notifying us.

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

1. Acupuncture Services

Acupuncture services for the following conditions:

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

Acupuncture services must be performed in an office setting within the lawful scope of practice of a health care provider licensed under the Maryland Health Occupations Article including but not limited to one of the following:

- Doctor of Medicine.
- Doctor of Osteopathy.
• Chiropractor.
• Acupuncturist.

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

Non-Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as we determine appropriate) between facilities when the transport is any of the following:
• From a non-Network Hospital to a Network Hospital.
• To a Hospital that provides a higher level of care that was not available at the original Hospital.
• To a more cost-effective acute care facility.
• From an acute facility to a sub-acute setting.

3. Congenital Heart Disease Surgeries
Congenital heart disease (CHD) surgeries which are ordered by a Physician. CHD surgical procedures include surgeries to treat conditions such as coarctation of the aorta, aortic stenosis, tetralogy of fallot, transposition of the great vessels and hypoplastic left or right heart syndrome.

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

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

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

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

4. 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 health care provider practicing within the lawful scope of the health care provider’s license under the Maryland Health Occupations Article.

• The dental damage is severe enough that initial contact with a health care provider occurred within 72 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the injury and if extenuating circumstances exist due to the severity of the Injury.)

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

Dental services to repair damage caused by accidental Injury must 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 are the only clinically acceptable treatment.
- Replacement of lost teeth due to the Injury by implant, dentures or bridges.

5. Diabetes Services

**Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care**

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Diabetes outpatient self-management training, education and medical nutrition therapy services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals.

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

Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes.

**Diabetic Self-Management Items**

Insulin pumps and all other medically appropriate and necessary equipment and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person. An insulin pump is subject to all the conditions of coverage stated under Durable Medical Equipment. Benefits for blood glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described under the Outpatient Prescription Drug Rider.

6. Durable Medical Equipment

Durable Medical Equipment that meets each of the following criteria:

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.
• Not consumable or disposable except as needed for the effective use of covered Durable Medical Equipment.

• Not of use to a person in the absence of a disease or disability.

Benefits under this section include Durable Medical Equipment provided to you by a Physician.

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.

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).

• Negative pressure wound therapy pumps (wound vacuums).

• Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. 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).

• Burn garments.

• Insulin pumps and all related necessary supplies as described under Diabetes Services.

• External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this Certificate.

Benefits under this section do not include any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body.

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

Benefits are available for repairs and replacement, except that:

• Benefits for repair and replacement do not apply to damage due to misuse, malicious breakage or gross neglect.

• Benefits are not available to replace lost or stolen items.

7. Emergency Health Services - Outpatient

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

Benefits under this section include the facility charge, supplies and all professional services required to stabilize your condition and/or initiate treatment. This includes placement in an observation bed for the purpose of monitoring your condition (rather than being admitted to a Hospital for an Inpatient Stay).
8. 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.

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

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

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 this Certificate, only for Covered Persons who have any 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 or, for Enrolled Dependent children, when a wearable hearing aid would not be suitable to optimize audibility and listening skills in the environment commonly experienced by children.

9. Home Health Care

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

- Except for the services required by state law listed below, services that consist of a plan of treatment that is established and approved in writing by the Covered Person's Physician where institutionalization of the Covered Person would be required if home health care was not provided; and
- Are provided in the Covered Person's home by a person licensed under the Health Occupations Article of the Maryland Code; and
- Do not constitute Custodial Care; and
- Are not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair.

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

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

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

- One home visit and an additional home visit when prescribed by a Physician for a mother and newborn child following discharge from a Hospital prior to a 48 hour Inpatient Stay for an uncomplicated delivery or 96 hours for a cesarean delivery. Such newborn home visits are not subject to any Copayment or Coinsurance payments shown in the Schedule of Benefits.

- One home visit when prescribed by a Physician for a mother and newborn child following discharge from a Hospital after a 48 hour Inpatient Stay for an uncomplicated delivery or 96 hours for a cesarean delivery. Such a home visit is not subject to any Copayment or Coinsurance payments shown in the Schedule of Benefits.

Such home visits shall be provided with the following conditions:

- They will comply with generally accepted standards of nursing practice for home care of a mother and newborn child;

- They will be provided by registered nurse with at least one year of experience in maternal and child health nursing or community health nursing with an emphasis on maternal and child health; and

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

10. Hospice Care

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

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

- "Family counseling" means counseling provided to the immediate family or family caregiver of the terminally ill person for the purpose of learning to care for the terminally ill person and to adjust to the death of the terminally ill person.

- "Family caregiver" means a relative by blood, marriage, or adoption who lives with or is the primary caregiver of the terminally ill person.

- "Immediate family" means the spouse, parents, siblings, grandparents, and children of a terminally ill person.

- "Terminally ill" means a medical prognosis given by a Physician that a Covered Person's life expectancy is six months or less.

Hospice care includes the following specific services:

- Inpatient and outpatient services.

- Part-time nursing care by or supervised by a registered graduate nurse.

- Counseling, including dietary counseling, for the terminally ill person.

- Family counseling for family caregivers and the immediate family before the death of the terminally ill person.
• All medical supplies, medications and equipment required to maintain the comfort and manage the pain of the terminally ill person.

Benefits are available when hospice care is received from a licensed hospice agency.

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

11. Hospital - Inpatient Stay

Services and supplies provided during an Inpatient Stay in a Hospital. Benefits are available for:

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

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

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

12. Infertility Services

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

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

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

• Have failed to achieve a Pregnancy after a year of regular, unprotected intercourse if the woman is under age 35, or after six months, if the woman is over age 35.
• Be under age 44, if female.
• Have infertility that is not related to voluntary sterilization or failed reversal of voluntary sterilization.

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

13. Lab, X-Ray and Diagnostics - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office include:
- Lab and radiology/X-ray.
- Mammography.
- Bone mass measurement testing for diagnostic and treatment purposes. Benefits for bone mass measurement performed for prevention of osteoporosis is provided as described under Preventive Care Services.

Benefits under this section include:

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

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

CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient.

14. Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

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

Benefits under this section include:

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

When these services are performed in a Physician's office, Benefits are described under Physician's Office Services - Sickness and Injury.

15. Mental Health Services

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

Benefits include the following services provided:

- Diagnostic evaluations and assessment (Including psychological and neuropsychological testing for diagnostic purposes).
- Treatment planning.
- Treatment and/or procedures.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention and Residential Crisis Services.
- Services at a Residential Treatment Facility.
- Partial Hospitalization/Day Treatment.
• 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 a Semi-private Room basis.

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 Designee may become available to you as a part of your Mental Health Services Benefit. The Mental Health 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 Mental Illness 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 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.

**16. Neurobiological Disorders - Autism Spectrum Disorder Services**

Psychiatric services for Autism Spectrum Disorder (otherwise known as neurodevelopmental 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 pose danger to self, others and property, and impairment in daily functioning.

This section describes only the psychiatric component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Service for which Benefits are available under the applicable medical Covered Health Services categories in this *Certificate*.

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

- Diagnostic evaluations and assessment (Including psychological and neuropsychological testing for diagnostic purposes).
- Treatment planning.
- Treatment and/or procedures.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention and Residential Crisis Services.
- Services at a Residential Treatment Facility.
- Partial Hospitalization/Day Treatment.
- 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 a Semi-private Room basis.
We encourage you to contact the Mental Health/Substance Use Disorder Designee for referrals to providers and coordination of care.

17. Ostomy Supplies
Benefits for ostomy supplies are limited to the following:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

18. Pharmaceutical Products - Outpatient
Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy. Benefits under this section do not include medications for the treatment of infertility.

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

A step therapy requirement may not be imposed if:

- The step therapy drug has not been approved by the U.S. Food and Drug Administration (FDA) for the medical condition being treated; or
- The prescribing provider provides supporting medical information to us that a Prescription Drug Product:
  - Was ordered by a prescribing provider for the Covered Person within the past 180 days; and
  - Based on the professional judgment of the prescribing provider, was effective in treating the Covered Person's medical condition.

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

20. Physician's Office Services - Sickness and Injury
Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is free-standing, located in a clinic or located in a Hospital.
Covered Health Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing which is ordered by the Physician and authorized in advance by us.

Benefits under this section include allergy injections.

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

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

When a test is performed or a sample is drawn in the Physician's office and then sent outside the Physician's office for analysis or testing, Benefits for lab, radiology/X-rays and other diagnostic services that are performed outside the Physician's office are described in Lab, X-ray and Diagnostics - Outpatient.

### 21. Pregnancy - Maternity Services

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

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

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. It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs designed to achieve the best outcomes for you and your baby.

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 an uncomplicated cesarean section delivery.

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

In addition, whenever 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 the cost of additional hospitalization for the newborn for up to four days as required by state law.
22. Preventive Care Services

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

- Evidence-based items or services, inclusive of current recommendations for breast cancer, that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force. Note that recommendations of the United States Preventive Services Task Force regarding breast cancer screening, mammography and prevention issued in or around November 2009 are not considered to be current.

- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

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

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

Benefits defined under the Health Resources and Services Administration (HRSA) requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. You can obtain additional information on how to access Benefits for breast pumps by going to www.myuhc.com or by calling Customer Care at the telephone number on your ID card.

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

- Which pump is the most cost effective.
- Whether the pump should be purchased or rented.
- Duration of a rental.
- Timing of an acquisition.

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

- Breast cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society. Breast cancer screening is not subject to a deductible, as described in the Schedule of Benefits.

- Screening colonoscopy or sigmoidoscopy and other colorectal cancer screening tests in accordance with the latest screening guidelines issued by the American Cancer Society.

- Prostate cancer screening including digital rectal exams and prostate-specific antigen (PSA) blood tests for:
  - Male Covered Persons who are between the ages of 40 and 75; or
  - When used for the purpose of guiding patient management in monitoring the response to prostate cancer treatment; or
  - When used for staging in determining the need for a bone scan in patients with prostate cancer; or
  - When used for Covered Persons who are at high risk for prostate cancer.
Bone mineral density tests including a bone mass measurement (a radiologic or radioisotopic procedure, or other scientifically proven technology) for the prevention of osteoporosis when the bone mass measurement is requested by a Physician, and:

- You are an estrogen deficient individual at risk for osteoporosis; or
- You show a specific sign suggestive of spinal osteoporosis, including roentgenographic osteopenia or roentgenographic evidence suggestive of collapse, wedging, or ballooning of one or more thoracic or lumbar vertebral bodies and are a candidate for therapeutic intervention or for an extensive diagnostic evaluation for metabolic bone disease; or
- You are receiving long-term glucocorticoid (steroid) therapy; or
- You have hyperparathyroidism; or
- You are being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

An annual chlamydia screening test for:

- Women who are (i) younger than 20 years old who are sexually active, and (ii) at least 20 years old who have multiple risk factors; and
- Men who have multiple risk factors.

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

"Chlamydia screening test" means any laboratory test that:

- Specifically detects for infection by one or more agents of chlamydia trachomatis; and
- Is approved for this purpose by the U.S. Food and Drug Administration (FDA).

A human papillomavirus screening test at the testing intervals recommended for cervical cytology screenings by the American College of Obstetricians and Gynecologists.

- "Human papillomavirus screening test" means any laboratory test that:
  - Specifically detects for infection by one or more agents of the human papillomavirus; and
  - Is approved for this purpose by the U.S. Food and Drug Administration (FDA).

23. Prosthetic Devices

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

- Artificial arms, legs, feet and hands.
- Artificial face, eyes, ears and nose.
- Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. Benefits include mastectomy bras and lymphedema stockings for the arm.
- Components of prosthetic devices.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body.

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

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

Benefits are available for repairs and replacement, except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices.

24. Reconstructive Procedures

Reconstructive procedures when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

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

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

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

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

25. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

Short-term outpatient rehabilitation services, limited to:

- Physical therapy.
- Occupational therapy.
- Manipulative Treatment.
- Speech therapy.
- Pulmonary rehabilitation therapy.
- Cardiac rehabilitation therapy.
- Post-cochlear implant aural therapy.
- Cognitive rehabilitation therapy.
Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits under this section include rehabilitation services provided in a Physician’s office or on an outpatient basis at a Hospital or Alternate Facility.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed Manipulative Treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive Manipulative Treatment.

Please note that we will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorder. We will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.

### 26. Scopic Procedures - Outpatient Diagnostic and Therapeutic

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

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

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under Surgery - Outpatient. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Benefits under this section include:

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

When these services are performed for preventive screening purposes, Benefits are described under Preventive Care Services.

### 27. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

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

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

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

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

Skilled care is skilled nursing, skilled teaching and skilled rehabilitation services 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 dressing, feeding, bathing or transferring from a bed to a chair.
• It requires clinical training in order to be delivered safely and effectively.

We will determine if Benefits are available by reviewing both the skilled 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.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

28. Substance Use Disorder Services
Substance Use Disorder Services (also known as substance-related and addictive disorders services) include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility, or in a provider’s office.

Benefits include the following services provided:
• Diagnostic evaluations and assessment (Including psychological and neuropsychological testing for diagnostic purposes).
• Treatment planning.
• Treatment and/or procedures.
• Referral services.
• Medication management.
• Individual, family, therapeutic group and provider-based case management services.
• Crisis intervention and Residential Crisis Services.
• Services at a Residential Treatment Facility.
• Partial Hospitalization/Day Treatment.
• 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 a Semi-private Room basis.

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

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 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.

29. Surgery - Outpatient

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

Benefits under this section include certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

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

Benefits under this section include:

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

30. Therapeutic Treatments - Outpatient

Therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

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

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

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 Physician Fees for Surgical and Medical Services.

31. Transplantation Services

Organ and tissue transplants when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include bone marrow, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.

Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Policy.
We have specific guidelines regarding Benefits for transplant services. Contact us at the telephone number on your ID card for information about these guidelines.

32. 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 - Sickness and Injury.

Additional Benefits Required By Maryland Law

33. Amino Acid-Based Elemental Formula
Benefits will be provided for amino acid-based elemental formula, regardless of delivery method, for the diagnosis and treatment of:

   a. Immunoglobulin 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.

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

35. Child Wellness Services
Benefits for child wellness services may not be subject to a deductible and include:

   - Office visits and related expenses for childhood and adolescent immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control;
   - Services for hereditary and metabolic newborn screening and follow-up visits from birth to four weeks of age including visits for the collection of samples before two weeks of age;
   - Universal hearing screening of newborns provided by a Hospital before discharge;
   - All visits and cost of services for age-appropriate screening tests for tuberculosis, anemia, lead toxicity, hearing and vision as determined by the American Academy of Pediatrics;
   - Visits for obesity evaluation and management.
   - All visits for and costs of developmental screening as recommended by the American Academy of Pediatrics.
   - Physical examinations, developmental assessments, parental anticipatory guidance and laboratory tests considered necessary by the Physician for services described above.
36. Treatment of Cleft Lip or Palate or Both
Benefits for inpatient or outpatient orthodontic services, oral surgery, and otologic, audiological, and speech/language treatment for a Covered Person in connection with the birth defect of cleft lip, cleft palate, or both. Services must be provided by or under the direction of a Physician.

37. Clinical Trials
Routine patient care costs incurred during participation in a qualifying clinical trial for the treatment of:

- Cancer or other life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

- Cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.

- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.

- Other diseases or disorders which are not life threatening for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from participation in a qualifying clinical trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the qualifying clinical trial as defined by the researcher.

Routine patient care costs for qualifying clinical trials include:

- Covered Health Services for which Benefits are typically provided absent a clinical trial.

- Covered Health Services required solely for the provision of the Experimental or Investigational Service(s) or item, the clinically appropriate monitoring of the effects of the service or item, or the prevention of complications.

- Covered Health Services needed for reasonable and necessary care arising from the provision of an Experimental or Investigational Service(s) or item.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service(s) or item. The only exceptions to this are:
  - Certain Category B devices.
  - Certain promising interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with our medical and drug policies.

- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.

- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.
With respect to cancer or other life-threatening diseases or conditions, a qualifying clinical trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and which meets any of the following criteria in the bulleted list below.

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

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - National Institutes of Health (NIH). (Includes National Cancer Institute (NCI).)
  - Centers for Disease Control and Prevention (CDC).
  - Agency for Healthcare Research and Quality (AHRQ).
  - Centers for Medicare and Medicaid Services (CMS).
  - A cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Department of Veterans Affairs. A "cooperative group" for the purpose of this Benefit includes the:
    - National Cancer Institute Clinical Cooperative Group;
    - National Cancer Institute Community Clinical Oncology Program;
    - AIDS Clinical Trials Group; and
    - Community Programs for Clinical Research in AIDs.
  - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
  - The Department of Veterans Affairs, the Department of Defense or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to meet both of the following criteria:
    - Comparable to the system of peer review of studies and investigations used by the National Institutes of Health.
    - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- The treatment being provided in a clinical trial is approved by an institutional review board of an institution in the State which has a multiple project assurance contract approved by the Office of Protection from Research Risks of the National Institutes of Health. An entity seeking coverage for treatment in a clinical trial approved by such institutional review board shall post electronically and keep up-to-date a list of the clinical trials meeting the requirements for a qualifying clinical trial as described above.
For the purpose of this Benefit, a "multiple project assurance contract" means a contract between an institution and the federal Department of Health and Human Services that defines the relationship of the institution to the federal Department of Health and Human Services and sets out the responsibilities of the institution and the procedures that will be used by the institution to protect human subjects.

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

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

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

(A) Is a child seven years of age or younger or is developmentally disabled;

- Is an individual for whom a successful result cannot be expected from dental care provided under a local anesthesia because of a physical, intellectual, or other medically compromising condition; and
- Is an individual for whom a superior result can be expected from dental care provided under general anesthesia; or

(B) Is an extremely uncooperative, fearful, or uncommunicative child who is 17 years of age or younger with dental needs of such magnitude that treatment should not be delayed or deferred; and

- Is an individual for whom lack of treatment can be expected to result in oral pain, infection, loss of teeth, or other increased oral or dental morbidity.
- Such services must be provided under the direction of a Physician or dentist. Benefits are not provided for expenses for the diagnosis or treatment of dental disease.

39. Habilitative Services

Except for habilitative services provided in early intervention and school services, habilitative services for Enrolled Dependent children from 0 - 19 years old.

"Habilitative services" means 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 habilitative 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 Autism Spectrum Disorder; cerebral palsy; intellectual disability; down syndrome; spina bifida; hydroencephalocele; and congenital or genetic developmental disabilities. The limits for physical, speech and occupational therapy do not apply to the visits received in connection with this Benefit.

40. Hair Prosthesis

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

41. 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:

- 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 two 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, or
  ▪ 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 the American Fertility Society minimal standards for programs of in vitro fertilization.

See Schedule of Benefits for Benefit conditions and maximum Benefit.

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

"Low protein modified food product" means a food product that is:
• Specially formulated to have less than one gram of protein per serving; and
• Intended to be used under the direction of a Physician for the dietary treatment of an inherited metabolic disease.

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

"Medical food" means a food that is:
• Intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation; and
• Formulated to be consumed or administered enterally under the direction of a Physician.

43. Surgical Morbid Obesity Treatment
Surgical treatment of morbid obesity that is:
• Recognized by the National Institutes of Health (NIH) as effective for the long-term reversal of morbid obesity; and
• Consistent with criteria approved by the National Institutes of Health.

For purposes of this Benefit, the term "morbid obesity" is defined as a body mass index that is:
• Greater than 40 kilograms per meter squared; or
• Equal to or greater than 35 kilograms per meter squared with a comorbid medical condition including hypertension, a cardiopulmonary condition, sleep apnea, or diabetes.

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

Covered Health Services delivered through the use of interactive audio, video, or other telecommunications or electronic technology by a Physician at a site other than the site at which the patient is located.

Telemedicine does not include:

1) An audio-only telephone conversation between a health care provider and a patient;
2) An electronic mail message between a health care provider and a patient; or
3) A facsimile transmission between a health care provider and a patient.
Section 2: Exclusions and Limitations

How We Use Headings in this Section
To help you find specific exclusions more easily, we use headings (for example A. Alternative Treatments below). 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 is true:

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

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

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

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

A. Alternative Treatments
1. Acupressure.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.
6. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in Section 1: Covered Health Services.

B. Dental
1. Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia).
This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only in Section 1: Covered Health Services.

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

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

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

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

Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth or gums. Examples include:
   - Extraction, restoration and replacement of teeth.
   - Medical or surgical treatments of dental conditions.
   - Services to improve dental clinical outcomes.

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

3. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only in Section 1: Covered Health Services.

4. Dental braces (orthodontics). This exclusion does not apply to cleft lip/palate-related dental services for which Benefits are provided as described under Treatment of Cleft Lip or Palate or Both in Section 1: Covered Health Services.

5. Treatment of congenitally missing, malpositioned or supernumerary teeth, even if part of a Congenital Anomaly.

C. Devices, Appliances and Prosthetics

1. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces.

3. Cranial banding.

4. The following items are excluded, even if prescribed by a Physician:
   - Blood pressure cuff/monitor.
   - Enuresis alarm.
   - Non-wearable external defibrillator.
• Trusses.
• Ultrasonic nebulizers.

5. Devices and computers to assist in communication and speech.
7. Repairs to prosthetic devices due to misuse, malicious damage or gross neglect.
8. Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

D. Drugs
1. Prescription drug products for outpatient use that are filled by a prescription order or refill. For Benefit plans that include the Outpatient Prescription Drug Rider, Benefits for outpatient prescription drugs are provided as described under the Outpatient Prescription Drug Rider.
2. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. For Benefit plans that include the Outpatient Prescription Drug Rider, Benefits for outpatient prescription drugs are provided as described under the Outpatient Prescription Drug Rider.
3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.
4. Over-the-counter drugs and treatments.
5. Growth hormone therapy.

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

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

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

This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.
4. Treatment of flat feet.
5. Treatment of subluxation of the foot.
7. Shoe orthotics.
8. Shoe inserts.

G. Medical Supplies
1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
   - Compression stockings.
   - Ace bandages.
   - Gauze and dressings.
   - Urinary catheters.

This exclusion does not apply to:
   - Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under Durable Medical Equipment in Section 1: Covered Health Services.
   - Diabetic supplies for which Benefits are provided as described under Diabetes Services in Section 1: Covered Health Services.
   - Disposable supplies for which Benefits are provided as described under Home Health Care and Hospice Care in Section 1: Covered Health Services.
   - Ostomy supplies for which Benefits are provided as described under Ostomy Supplies in Section 1: Covered Health Services.

2. Tubings and masks except when used with Durable Medical Equipment as described under Durable Medical Equipment in Section 1: Covered Health Services.

H. Mental Health
In addition to all other exclusions listed in this Section 2: Exclusions and Limitations, the exclusions listed directly below apply to services described under Mental Health Services in Section 1: Covered Health Services.

2. Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act.
3. Treatment for Mental Illnesses that in the professional judgment of health care providers are deemed untreatable or not Medically Necessary.
4. Mental Health Services as a treatment for other conditions that may be a focus of clinical attention as listed in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
5. All unspecified disorders in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

6. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 9: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:
   - Medically Necessary.
   - Described as a Covered Health Service in this Policy under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
   - Not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations*.

I. Neurobiological Disorders - Autism Spectrum Disorder

In addition to all other exclusions listed in this *Section 2: Exclusions and Limitations*, the exclusions listed directly below apply to services described under *Neurobiological Disorders - Autism Spectrum Disorder Services* in *Section 1: Covered Health Services*.

1. Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.

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

3. Treatment for Autism Spectrum Disorder that in the professional judgment of health care providers are deemed untreatable or not Medically Necessary.

4. All unspecified disorders in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

5. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 9: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:
   - Medically Necessary.
   - Described as a Covered Health Service in this Policy under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
   - Not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations*.

J. Nutrition

1. Individual and group nutritional counseling. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:
   - Nutritional education is required for a disease in which patient self-management is an important component of treatment.
   - There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.
2. Enteral feedings, even if the sole source of nutrition. This exclusion does not apply to Benefits which are provided as described under Medical Foods or Amino Acid-Based Elemental Formula in Section 1: Covered Health Services.

3. Infant formula and donor breast milk. This exclusion does not apply to Benefits which are provided as described under Medical Foods or Amino Acid-Based Elemental Formula in Section 1: Covered Health Services.

4. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods). This exclusion does not apply to Benefits which are provided as described under Medical Foods or Amino Acid-Based Elemental Formula in Section 1: Covered Health Services.

K. Personal Care, Comfort or Convenience

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

L. Physical Appearance

1. Cosmetic Procedures. See the definition in Section 9: Defined Terms. Examples include:
   • Pharmacological regimens, nutritional procedures or treatments.
   • Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   • Skin abrasion procedures performed as a treatment for acne.
   • Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
   • Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
   • Treatment for spider veins.
   • Hair removal or replacement by any means.

2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See Reconstructive Procedures in Section 1: Covered Health Services.

3. Treatment of benign gynecomastia (abnormal breast enlargement in males).

4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility and diversion or general motivation.

5. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.

6. Wigs regardless of the reason for the hair loss. This exclusion does not apply to hair prosthesis for which Benefits are provided as described under Hair Prosthesis under Additional Benefits Required by Maryland Law in Section 1: Covered Health Services.

M. Procedures and Treatments

1. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty.

2. Medical and surgical treatment of excessive sweating (hyperhidrosis).

3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
4. Rehabilitation services and Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment.

5. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorder. This exclusion does not apply to speech therapy services for which Benefits are provided as described under Treatment of Cleft Lip or Palate or Both or Habilitative Services under Additional Benefits Required by Maryland Law in Section 1: Covered Health Services.

6. Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.

7. Psychosurgery.

8. Sex transformation operations and related services.

9. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.


11. Services for non-surgical treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature.

12. Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for Covered Persons because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea. This exclusion does not apply to the diagnostic and surgical procedures involving bones or joints of the face, neck or head for which Benefits are provided as described under Bones of the Face, Neck, and Head under Additional Benefits Required by Maryland Law in Section 1: Covered Health Services.


14. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.

15. Breast reduction surgery except for coverage as required by the Women’s Health and Cancer Rights Act of 1998 for which Benefits are described under Reconstructive Procedures in Section 1: Covered Health Services.

N. Providers

1. Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or 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 which 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 breast cancer screening.

O. Reproduction
1. The following infertility treatment-related services:
   • Cryo-preservation and other forms of preservation of reproductive materials. This exclusion does not apply to Benefits for in vitro fertilization procedures for which Benefits are provided as described under In Vitro Fertilization under Additional Benefits Required by Maryland Law in Section 1: Covered Health Services.
   • Long-term storage of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue.
   • Donor services.
2. Surrogate parenting, donor eggs, donor sperm and host uterus.
3. The reversal of voluntary sterilization.

P. 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. Examples include coverage required by workers’ compensation or similar legislation. However this exclusion does not apply to health services provided through the Maryland Medical Assistance Program, payments received through no-fault automobile insurance or to a hospital or other institution of the state or of a county or municipal corporation of the state, whether or not the hospital or other institution is deemed charitable.

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

2. Health 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.

Q. Substance Use Disorders
In addition to all other exclusions listed in this Section 2: Exclusions and Limitations, the exclusions listed directly below apply to services described under Substance Use Disorder Services in Section 1: Covered Health Services.

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 9 - Defined Terms for definitions of Alcohol Abuse and Drug Abuse.

2. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
3. Substance-induced sexual dysfunction disorders and substance-induced sleep disorders.
5. All unspecified disorders in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

6. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 9: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:
   - Medically Necessary.
   - Described as a Covered Health Service in this Policy under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
   - Not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations*.

**R. Transplants**

1. Health services for organ and tissue transplants, except those described under *Transplantation Services* in *Section 1: Covered Health Services*.

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

3. Health services for transplants involving permanent mechanical or animal organs.

**S. 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. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at our discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in *Section 1: Covered Health Services*.

**T. Types of Care**

1. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.

2. Custodial Care or maintenance care.

3. Domiciliary care.

4. Private Duty Nursing.

5. Respite care.

6. Rest cures.

7. Services of personal care attendants.

8. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

**U. Vision and Hearing**

1. Purchase cost and fitting charge for eyeglasses and contact lenses.
2. Routine vision examinations, including refractive examinations to determine the need for vision correction.

3. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants).

4. Eye exercise or vision therapy.

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

6. Bone anchored hearing aids except when either of the following applies:
   - 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 or, for Enrolled Dependent children, when a wearable hearing aid would not be suitable to optimize audibility and listening skills in the environment commonly experienced by children.

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

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

V. All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 9: Defined Terms. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:
   - Medically Necessary.
   - Described as a Covered Health Service in this Certificate under Section 1: Covered Health Services and in the Schedule of Benefits.
   - Not otherwise excluded in this Certificate under Section 2: Exclusions and Limitations.

2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:
   - Required solely for purposes of school, sports or camp, travel, career or employment, insurance, marriage or adoption.
   - Related solely to judicial or administrative proceedings or orders.
   - Conducted solely for purposes of medical research.
   - Required solely to obtain or maintain a license of any type.

3. 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. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war, or terrorism in non-war zones.
4. Except as described below under *Extension of Coverage* in *Section 4: When Coverage Ends*, health services received after the date your coverage under the Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Policy ended.

5. 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. This exclusion does not apply to reimbursement which may be required by us, payable to the *Department of Health and Mental Hygiene*, when such department has provided a benefit to a Covered Person for a service that is a Covered Health Service under this Policy.

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

7. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.

8. Autopsy.

9. Foreign language and sign language services.

10. Health services related to a non-Covered Health Service. This exclusion does not apply to services we would otherwise determine to be Covered Health Services if they are Medically Necessary ancillary services that would otherwise be covered under the Policy or are services required to treat complications that arise from the non-Covered Health Service.

   For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

11. Payment of any claim, bill, or other demand or request for payment for health care services that the appropriate regulatory board determines were provided as a result of a prohibited referral. "Prohibited referral" means a referral prohibited by 1-302 of the *Maryland Health Occupations Article*. 
Section 3: When Coverage Begins

How to Enroll

Eligible Persons must complete an enrollment form. The Enrolling Group will give the necessary forms to you. The Enrolling Group will then submit the 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 that you receive on or after your first day of coverage related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Policy. These Benefits are subject to any prior carrier's obligations under state law or contract.

You should notify us of your hospitalization within 48 hours of the day your coverage begins, or as soon as is reasonably possible. For Benefit plans that have a Network Benefit level, Network Benefits are available only if you receive Covered Health Services from Network providers.

Who is Eligible for Coverage

The Enrolling Group determines who is eligible to enroll under the Policy and who qualifies as a Dependent.

Eligible Person

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 9: Defined Terms.

Eligible Persons must reside within the United States.

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

Dependent

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

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

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

When to Enroll and When Coverage Begins

Except as described below, Eligible Persons may not enroll themselves or their Dependents.
Initial Enrollment Period
When the Enrolling Group purchases coverage under the Policy from us, the Initial Enrollment Period is the first period of time when Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date 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.

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

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.

New Eligible Persons
Coverage for a new Eligible Person and his or her Dependents begins on the date agreed to by the Enrolling Group if we receive the completed enrollment form and any required Premium within 31 days of the date the new Eligible Person first becomes eligible.

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

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

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

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

For all other Dependents:

Coverage for all other Dependents begins on the date of the event if we receive the completed enrollment form and any required Premium within 31 days of the event that makes the new Dependent eligible.

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 not elected.

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

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

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

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

- The Eligible Person previously declined coverage under the Policy, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under Medicaid or Children's Health Insurance Program (CHIP). Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date of determination of subsidy eligibility.
• The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period; and

• Coverage under the prior plan ended because of any of the following:
  ▪ Loss of eligibility (including legal separation, divorce or death).
  ▪ The employer stopped paying the contributions. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer.
  ▪ In the case of COBRA continuation coverage, the coverage ended.
  ▪ The Eligible Person and/or Dependent no longer 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. For purpose of the “date of the event” below, the date of the event for exceeding the lifetime limit on all benefits would be the date a claim is denied for exceeding such lifetime limit.
  ▪ The Eligible Person and/or Dependent loses eligibility under Medicaid or Children’s Health Insurance Program (CHIP). Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date coverage ended.

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

For an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period because they had existing health coverage under another plan, 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.
Section 4: When Coverage Ends

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.

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 Extension of Coverage.

When your coverage ends, we will still pay claims for Covered Health Services that you received before the date on which your coverage ended. However, once your coverage ends, we will not pay claims for any health services received after that date, except as noted below under Extension of Coverage.

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

Please note that for Covered Persons who are subject to the Extension of Coverage provision later in this section, entitlement to Benefits ends as described in that section.

Events Ending Your Coverage

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**
  
  Your coverage ends on the date the Policy ends. In the event the entire Policy ends, the Enrolling Group is responsible for notifying you that your coverage has ended.

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

- **We Receive Notice to End Coverage**
  
  Your coverage ends on the last day of the calendar month in which we receive 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.

- **Subscriber Retires or Is Pensioned**
  
  Your coverage ends the last day of the period for which the Premium has been paid during which the Subscriber is retired or receiving benefits under the Enrolling Group's pension or retirement 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 available for retirees.
Other Events Ending Your Coverage

When the following happens, we will provide 30 days advance written notice to the Subscriber that coverage will end on the date we identify in the notice:

- **Fraud or Intentional Misrepresentation of a Material Fact**
  
  You committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include knowingly providing incorrect information relating to another person's eligibility or status as a Dependent.

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

Coverage for a Disabled Dependent Child

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

- Is not able to be self-supporting because of mental or physical incapacity that originated before the Enrolled Dependent child attained the limiting age.
- Depends mainly on the Subscriber for support.
- Is unmarried.

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

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

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

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

Extension of Coverage

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

- The Covered Person is Totally Disabled.
- The Covered Person is undergoing treatment other than treatment for an accidental dental injury as described under *Dental Services - Accident Only* in *Section 1: Covered Health Services*.
- The Covered Person is confined in a Hospital.
The temporary extension will continue until (a) the day the Total Disability or treatment ends; or (b) 12 months from the date coverage under the Policy would otherwise have terminated whichever occurs first. No Premium will be charged for this coverage extension.

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

- The Covered Person is undergoing dental treatment in connection with an accidental injury as described under Dental Services - Accident Only in Section 1: Covered Health Services.

The temporary extension will continue for a period of 90 days from the date coverage under the Policy would otherwise have terminated if the dental treatment:(1) begins before the date coverage terminates; and (2) requires two or more visits on separate days to the dentist's office.

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

Continuation of Coverage

If your coverage ends under the Policy, you may 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 the Policy, continuation coverage will end as scheduled under the prior plan or in accordance with federal or state law, whichever is earlier.

We are not the 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 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 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
Continued coverage shall terminate on the earlier of the following dates:

- Eighteen (18) months after the date continuation coverage began;
- For a Dependent child, the date coverage would otherwise terminate as described in Section 4: When Coverage Ends;
- The date coverage terminates for failure to make timely payment of the Premium;
- The date the Enrolling Group ceases to provide Benefits to its employees under a group contract;
- The date the Covered Person becomes eligible to be insured for hospital, medical, or surgical benefits under any insured or self-insured group health benefit program or plan that is written on an expense incurred basis or with a health maintenance organization;
- The date the Covered Person becomes covered under any hospital, medical, or surgical coverage under a non-group contract or policy that is written on an expense incurred basis or with a health maintenance organization;
- The date the Covered Person becomes entitled to benefits under Title XVIII of the Social Security Act; or
- 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 wishes 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 in (1) or (2) below.

(1) 60 days after the applicable change in status if on the date of the change the Subscriber is covered under the Policy or under another group contract issued to the same Enrolling Group. In this case coverage will be effective retroactive to the date of the applicable change in status.

(2) 30 days after the date the insured employee becomes eligible for coverage under a group contract issued to another employer, if the insured employee becomes covered under the new employer's group contract after the applicable change in status. In this case, coverage shall 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:

- For a Dependent child, the date coverage would otherwise terminate as described in Section 4: When Coverage Ends;
- The date the Enrolling Group ceases to provide Benefits to its employees under a group contract;
• The date the Covered Person becomes eligible to be insured for hospital, medical, or surgical benefits under any insured or self-insured group health benefit program or plan that is written on an expense incurred basis or with a health maintenance organization;

• The date the Covered Person becomes covered under any hospital, medical, or surgical coverage under a non-group contract or policy that is written on an expense incurred basis or with a health maintenance organization;

• The date the Covered Person becomes entitled to benefits under Title XVIII of the Social Security Act;

• For an Enrollment Dependent spouse, the date the Enrolled Dependent spouse remarries; or

• 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;

• For a Dependent child, the date coverage would otherwise terminate as described in Section 4: When Coverage Ends;

• The date coverage terminates for failure to make timely payment of the Premium;

• The date the Enrolling Group ceases to provide Benefits to its employees under a group contract;

• The date the Covered Person becomes eligible to be insured for hospital, medical, or surgical benefits under any insured or self-insured group health benefit program or plan that is written on an expense incurred basis or with a health maintenance organization;

• The date the Covered Person becomes covered under any hospital, medical, or surgical coverage under a non-group contract or policy that is written on an expense incurred basis or with a health maintenance organization;

• The date the Covered Person becomes entitled to benefits under Title XVIII of the Social Security Act;

• The date the Covered Person elects to terminate coverage.
Section 5: How to File a Claim

If You Receive Covered Health Services from a Network Provider

We pay Network providers directly for your Covered Health Services. If a Network provider bills you for any Covered Health Service, contact us. However, you are responsible for meeting any applicable deductible and for paying any required Copayments and Coinsurance to a Network provider at the time of service, or when you receive a bill 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, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described below.

You should submit a request for payment of Benefits within 90 days after the date of service. Failure to furnish the request for payment within the time required does not invalidate or reduce a claim if it was not reasonably possible to submit the request within the required time, if the request is furnished as soon as reasonably possible and, except in the absence of a legal capacity of the claimant, not later than one year from the time the request for payment is otherwise required. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Required Information

When you request payment of Benefits from us, you must provide us with all of the following information:

- The Subscriber's name and address.
- The patient's name and age.
- The number stated on your ID card.
- The name and address of the provider of the service(s).
- The name and address of any ordering Physician.
- A diagnosis from the Physician.
- An itemized bill from your provider that includes the Current Procedural Terminology (CPT) codes or a description of each charge.
- The date the Injury or Sickness began.
- A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

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

Payment of Benefits

We will pay Benefits within 30 days after we receive your request for payment that includes all required information. If a Subscriber provides written authorization to allow this, all or a portion of any Eligible Expenses due to a provider may be paid directly to the provider instead of being paid to the Subscriber.
But we will not reimburse third parties that have purchased or been assigned benefits by Physicians or other providers.

Benefits will be paid to you unless either of the following is true:

- The provider notifies us that your signature is on file, assigning benefits directly to that provider.
- You make a written request at the time you submit your claim.

We may refuse to directly reimburse a non-Network provider under an assignment of Benefits if:

- We receive notice of the assignment of Benefits after we have paid Benefits to the Covered Person.
- We, due to an inadvertent administrative error, have previously paid the Covered Person.
- You withdraw the assignment of Benefits before we paid the Benefits to the non-Network provider; or
- You paid the non-Network provider the amount due at the time of your service.

You do not have the right to bring any legal proceeding or action against us within 60 days of the date you submit your request for payment as directed above.

In addition, if a child has coverage through an insuring parent, we will pay Benefits to the non-insuring parent, health care provider, or the Department of Health and Mental Hygiene if the non-insuring parent incurs expenses for the health care provided to the child.
Section 6: Questions, Complaints and Appeals

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

What to Do if You Have a Question

Contact Customer Care at the telephone number shown on your ID card. Customer Care representatives are available to take your call during regular business hours, Monday through Friday.

What to Do if You Have a Complaint

Contact Customer Care at the telephone number shown on your ID card. Customer Care 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 Care representative can provide you with the appropriate address.

If the Customer Care 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 determination that a proposed or delivered Covered Health Service which would otherwise be covered under the Policy is not or was not, appropriate or efficient, and may result in non-coverage of the health service.

- "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.

- "Complaint" is a protest filed with the Insurance Commissioner that is either; a) an adverse decision complaint, or b) a complaint as allowed under the provision entitled Complaints below.

- "Grievance decision" is a final determination by us that arises from an adverse decision grievance filed with us under our internal adverse decision grievance process regarding an adverse decision.

- "Health Advocacy Unit" means the Health Education and Advocacy Unit in the Division of Consumer Protection of the Office of the Attorney General.

- "Health care provider" means a Hospital, or an individual who is licensed or otherwise authorized in the State of Maryland to provide health care services in the ordinary course of working or practice of a profession and is a treating provider of a Covered Person.

- "Your representative" means an individual who has been authorized by you to file a grievance or a complaint on your behalf.
Notice Requirements
All notification requirements provided to you, your representative, and/or your health care provider as described in this Section will be provided in a culturally and linguistically appropriate manner.

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

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

Internal Adverse Decision Grievance Process
Under the law, you must exhaust our internal adverse decision grievance process before you 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 an urgent medical condition for which services have not been rendered, you 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 following the verbal notification.

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

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

Adverse Decision Grievances

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

• The adverse decision grievance must be filed by you, your representative, or your health care provider on your behalf, with us within 60 days of receipt of our adverse decision letter unless the adverse decision is a retrospective denial in which case you have up to 180 days from the date of receipt to file an adverse decision grievance.

• For prospective denials (denials on health services that have not yet been rendered), we will render a grievance decision in writing within 30 working days after the filing date, unless it involves an emergency case as explained below. The “filing date” is the earlier of five days after the date the adverse decision grievance was mailed or the date of receipt. Unless written permission has been given per the fourth bulleted item below, you, your representative, or your health care provider on your behalf, have the right to file an adverse decision complaint with the Insurance Commissioner, if you have not received our grievance decision on or before the 30th working day after the filing date.

• For retrospective denials (denials on health services that have already been rendered), we will render a grievance decision within 45 working days after the filing date. Unless written permission has been given per the fourth bulleted item below, you, your representative, or your health care provider on your behalf, have the right to file an adverse decision complaint with the Insurance Commissioner (see below), if you have not received our grievance decision on or before the 45th working day after the filing date.

• With written permission from you, your representative, or your health care provider on your behalf, the time frame within which we must respond can be extended up to an additional 30 working days.

• If we need additional information in order to review the case, we will notify you, your representative and/or your health care provider within five working days after the filing date. We will assist you, your representative, or the health care provider in gathering the necessary medical records without further delay. If no additional information is available or is not submitted to us, we will render a decision based on the available information.
Except as described under the first two bullets in the Complaints provision above, for retrospective denials, you, your representative, or your health care provider on your behalf, must file an adverse decision grievance with us before filing an adverse decision complaint with the Insurance Commissioner, as described below.

Notice of our grievance decision may be verbally communicated to you, your representative, or your health care provider. Written notification of our grievance decision will be sent to you, your representative and any health care provider who filed an adverse decision grievance on your behalf within five working days after the grievance decision has been made. If we uphold the adverse determination, the denial notification will include a Notice of Grievance Decision. This Notice will include the information in the bulleted items under Adverse Decision above. 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 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.

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

Health Education and Advocacy Unit
Consumer Protection Division
Office of the Attorney General
200 St. Paul Place, 16th Floor
Baltimore, Maryland 21202
410-528-1840 or 1-877-261-8807 (toll free)
Fax number: 410-576-6571
E-mail: consumer@oag.state.md.us

Medical Directors
Our Medical Directors who are responsible for adverse decisions and grievance decisions may be reached at:

UnitedHealthcare Insurance Company
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.
The Insurance Commissioner will make a final decision on a complaint as follows:

- For an emergency case, written notice of the Insurance Commissioner's final decision will be sent to the Covered Person, the Covered Person's representative and/or the health care provider within one day after the Insurance Commissioner has given verbal notification of the final decision.

- For an adverse decision complaint involving a pending health service, written notice of the Insurance Commissioner's final decision will be sent to the Covered Person, the Covered Person's representative and/or the health care provider within 45 days after the adverse decision complaint is filed.

- For an adverse decision complaint involving a retrospective denial of health services already provided, written notice of the Insurance Commissioner's final decision will be sent to the Covered Person, the Covered Person's representative and/or the health care provider within 45 days after the adverse decision complaint is filed.

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

**Assistance from State Agencies**

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

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

Consumer Complaint & Investigation
Life and Health
Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, Maryland 21202
Telephone number: 1-800-492-6116
Fax number: (410) 468-2270 or (410) 468-2260

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

Office of the Attorney General
Health Education and Advocacy Unit
200 St. Paul Place, 16th Floor
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 Care 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 Commissioner; and

• The information shown below regarding assistance from the Health Advocacy Unit.

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

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

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

Health Education Advocacy Unit
Consumer Protection Division
Office of the Attorney General
200 St. Paul Place, 16th Floor
Baltimore, MD 21202
Telephone: 410/528-1840 or toll free at 1-877/261-8807; Fax#: 410/576-6571
Website address: www.oag.state.md.us

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

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

"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 lay person 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.
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 Plan. Plan is defined below.

The order of benefit determination rules below govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

Definitions

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

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

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

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

B. This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract
may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

D. Allowable Expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense.

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

1. The difference between the cost of a semi-private hospital room and a private room is not an Allowable Expense unless one of the Plans provides coverage for private hospital room expenses.

2. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.

3. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.

5. The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions and preferred provider arrangements.

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

F. Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.
**Order of Benefit Determination Rules**

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

A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

B. Except as provided in the next paragraph, a Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary unless the provisions of both Plans state that the complying plan is primary.

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

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

D. Each Plan determines its order of benefits using the first of the following rules that apply:

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

2. Dependent Child Covered Under More Than One Coverage Plan. Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:
   a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
      (1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
      (2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.
   b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:
      (1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary Plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.
(2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.

(3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.

(4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(a) The Plan covering the Custodial Parent.

(b) The Plan covering the Custodial Parent's spouse.

(c) The Plan covering the non-Custodial Parent.

(d) The Plan covering the non-Custodial Parent's spouse.

c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.

d) (i) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse’s plan, the rule in paragraph (5) applies.

(ii) In the event the dependent child's coverage under the spouse’s plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in subparagraph (a) to the dependent child's parent(s) and the dependent's spouse.

3. Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.

4. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.

5. Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

6. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.
Effect on the Benefits of This Plan

A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a Covered Person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

Right to Receive and Release Needed Information

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

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

Payments Made

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

Right of Recovery

If the amount of the payments we made is more than we should have paid under this COB provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or services provided for you. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.
Section 8: General Legal Provisions

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 or make treatment decisions. This means:

- 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 Covered Health Services, 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 any services that are not Covered Health Services.

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

Please refer to our Notice of Privacy Practices for details.

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 are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any deductible and any amount that exceeds Eligible Expenses.
- You are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.
- 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 to void the Policy after it has been in force for a period of two years. A statement made by any Covered Person under the Policy relating to insurability may not be used in contesting the validity of the insurance with respect to which the statement was made after the insurance has been in force before the contest for a period of 2 years during the Covered Person’s lifetime.

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

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

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.

Rebates and Other Payments
We may receive rebates for certain drugs that are administered to you in your home or in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet any applicable deductible. We do not pass these rebates on to you, nor are they applied to any deductible or taken into account in determining your Copayments or Coinsurance.

Interpretation of Benefits
We have the 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, the Schedule of Benefits and any Riders and/or Amendments.
- Make factual determinations related to the Policy and its Benefits.

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

In certain circumstances, for purposes of overall cost savings or efficiency, we may, in our 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.

**Information and Records**
We may use your individually identifiable health information to administer the Policy and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. We may request additional information from you to decide your claim for Benefits. We will keep this information confidential. We may also use your de-identified data for commercial purposes, including research, as permitted by law. More detail about how we may use or disclose your information is found in our *Notice of Privacy Practices*.

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

We have the right to release 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. Please refer to our *Notice of Privacy Practices*.

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, as permitted by law, we will designate other persons or entities to request records or information from or related to you, and to release those records as 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 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 any 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. Such refund is not required if the Benefits were paid under Medicaid or for the treatment of tuberculosis, mental illness, or another illness covered under the Policy that is received in a hospital or other institution of the state or of a county or municipal corporation of the state, whether or not the hospital or other institution is deemed charitable.

- All or some of the payment we made exceeded the Benefits under the Policy.

- All or some of the payment was made in error.

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

When the refund is due from the Covered Person and the Covered Person 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. 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 of the date written proof of loss is required to be furnished 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 *Schedule of Benefits*, the Enrolling Group's application, and any Riders and/or Amendments, constitutes the entire Policy. A change in the Policy is not valid:

- Until approved by an executive officer of the company, and
- Unless the approval is endorsed on the Policy or attached to the Policy.
Section 9: Defined Terms

**Alcohol 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.

**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 basis.

**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.

**Annual Deductible** - for Benefit plans that have an Annual Deductible, this is the amount of Eligible Expenses you must incur for Covered Health Services per year before we will begin paying for Benefits. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Refer to the Schedule of Benefits to determine whether or not your Benefit plan is subject to payment of an Annual Deductible and for details about how the Annual Deductible applies.

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

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

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

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

**Benefits** - your right to payment for Covered Health 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, the Schedule of Benefits and any attached Riders and/or Amendments.

**Coinsurance** - the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services.

**Congenital Anomaly** - a physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.
Copayment - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Services.

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

- The applicable Copayment.
- The Eligible Expense.

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, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Service in this Certificate under Section 1: Covered Health Services and in the Schedule of Benefits.
- Not otherwise excluded in this Certificate under Section 2: Exclusions and Limitations.

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 any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Dependent - the Subscriber's legal spouse or a child of the Subscriber or the Subscriber's spouse. All references to the spouse of a Subscriber shall include a Domestic Partner, except for the purpose of coordinating Benefits with Medicare. 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.

To be eligible for coverage under the Policy, a Dependent must be domiciled within the United States.

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 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 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.

Designated Facility - a facility that has entered into an agreement 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 geographic area. The fact that a Hospital is a Network Hospital does not mean that it is a Designated Facility.

Designated Network Benefits - for Benefit plans that have a Designated Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by a Physician or other...
provider that we have identified as Designated Network providers. Refer to the Schedule of Benefits to determine whether or not your Benefit plan offers Designated Network Benefits and for details about how Designated Network Benefits apply.

**Designated Physician** - a Physician that we've identified through our designation programs as a Designated provider. A Designated Physician may or may not be located within your geographic area. The fact that a Physician is a Network Physician does not mean that he or she is a Designated Physician.

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

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

**Drug 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.

**Durable Medical Equipment** - medical equipment that is all of the following:

- Can withstand repeated use.
- Is not disposable.
- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Is appropriate for use, and is primarily used, within the home.
- Is not implantable within the body.

**Eligible Expenses** - for Covered Health Services, incurred while the Policy is in effect, or while the Covered person is receiving Benefits under the Extension of Coverage provision in Section 4: When Coverage Ends, Eligible Expenses are determined by us as stated below and as detailed in the Schedule of Benefits.

Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines. We develop our reimbursement policy guidelines, in our discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

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

**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 within the United States.

**Emergency** - a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the Covered Person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

**Emergency Health Services** - with respect to an Emergency:

- 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, 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)).

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

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use except for coverage of a drug for an Off-Label Use of the drug if the drug is recognized for treatment in any of the standard reference compendia or in the medical literature.
- Subject to review and approval by the institutional review board of the treating facility for the proposed use. (Devices which are FDA approved under the Humanitarian Use Device exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exceptions:

- Clinical trials for which Benefits are available as described under Clinical Trials in Section 1: Covered Health Services.
- If you are not a participant in a qualifying clinical trial, as described under Clinical Trials in Section 1: Covered Health Services, and have a Sickness or condition 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.

**Genetic Testing** - examination of blood or other tissue for chromosomal and DNA abnormalities and alterations, or other expressions of gene abnormalities that may indicate an increased risk for developing a specific disease or disorder.

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

- A Hospital that has a valid operating certificate and is certified to provide home health care services; or
- A public or private health service or agency that is licensed as a Home Health Agency under Title 19, Subtitle 4 of the Maryland Health - General Article to provide coordinated home health care.

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

- It is 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.
- It 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.

**Initial Enrollment Period** - the initial period of time 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 long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

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

**Intensive Outpatient Treatment** - a structured outpatient mental health or substance-related and addictive disorders 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.

**Intermittent Care** - skilled nursing care that is provided or needed either:

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

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

**Manipulative Treatment** - the therapeutic application of chiropractic and/or osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.
Medically Necessary - health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms, that are all of the following as determined by us or our designee, within our sole discretion.

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

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

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

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

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

Mental Health 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.

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

A provider may enter into an agreement to provide only certain Covered Health 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.

**Network Benefits** - for Benefit plans that have a Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Network Benefits and for details about how Network Benefits apply.

**Non-Network Benefits** - for Benefit plans that have a Non-Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Non-Network Benefits and for details about how Non-Network Benefits apply.

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

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

**Out-of-Pocket Maximum** - for Benefit plans that have an Out-of-Pocket Maximum, this is the maximum amount you pay every year. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to an Out-of-Pocket Maximum and for details about how the Out-of-Pocket Maximum applies.

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

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

**Pharmaceutical Product(s)** - *U.S. Food and Drug Administration (FDA)*-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under the Policy.

**Pharmaceutical Product List** - a list that categorizes into tiers medications, products or devices that have been approved by the *U.S. Food and Drug Administration (FDA)*. 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 Pharmaceutical Product has been assigned through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

**Pharmaceutical Product List Management Committee** - the committee that we designate for, among other responsibilities, classifying Pharmaceutical Products into specific tiers.

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

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

**Policy** - the entire agreement issued to the Enrolling Group that includes all of the following:
• The Group Policy.
• This Certificate.
• The Schedule of Benefits.
• The Enrolling Group's application.
• Riders.
• Amendments.

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

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:
• No skilled services are identified.
• Skilled nursing resources are available in the facility.
• The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.
• The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.

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

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. (Note that any applicable Benefits for Outpatient Prescription Drugs while presented in Rider format, are not subject to payment of additional Premiums and are included in the overall Premium for Benefits under the Policy.) Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended in the Rider.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health 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.

Shared Savings Program - the Shared Savings Program provides access to discounts from the provider's charges when services are rendered by those non-Network providers that participate in that program. We will use the Shared Savings Program to pay claims when doing so will lower Eligible Expenses. We do not credential the Shared Savings Program providers and the Shared Savings Program providers are not Network providers. Accordingly, in Benefit plans that have both Network and Non-Network levels of Benefits, Benefits for Covered Health Services provided by Shared Savings Program providers will be paid at the Non-Network Benefit level (except in situations when Benefits for Covered Health Services provided by non-Network providers are payable at Network Benefit levels, as in the case of Emergency Health Services). When we use the Shared Savings Program to pay a claim, patient responsibility is limited to Coinsurance calculated on the contracted rate paid to the provider, in addition to any required deductible.

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

Skilled 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.
Substance Use Disorder Services - Covered Health Services for the diagnosis and treatment of Alcohol Abuse and Drug Abuse.

Total Disability or Totally Disabled - a Subscriber's inability to perform all of the substantial and material duties of his or her regular employment or occupation; and a Dependent's inability to perform the normal activities of a person of like age and sex.

Transitional 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 or 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.

Unproven Service(s) - services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)

- Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

We have a process by which we compile and review clinical evidence with respect to certain health services. From time to time, we issue medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com.

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, in our discretion, consider an otherwise Unproven 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.

Urgent Care Center - a facility 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.
Infertility Services Amendment

UnitedHealthcare Insurance Company

As described in this Amendment, the Policy is modified to provide Benefits for Infertility Services.

Because this Amendment reflects changes in requirements of insurance law of the State of Maryland, to the extent it 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 9: Defined Terms.

Section 1: Covered Health Services

Infertility Services in the Certificate, Section 1: Covered Health Services is replaced with the following:

Infertility Services

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

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

To be eligible for Benefits, the Covered Person must meet both of the following:

- Be under age 44, if female.
- Have infertility that is not related to voluntary sterilization or failed reversal of voluntary sterilization.

In addition, for a patient and the patient's spouse who are the opposite sex, they must have failed to achieve a Pregnancy after a year of regular, unprotected intercourse if the woman is under age 35, or after six months, if the woman is over age 35 in order to be eligible for Benefits.

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

UNITEDHEALTHCARE INSURANCE COMPANY

Jeffrey Alter, President
In Vitro Amendment

UnitedHealthcare Insurance Company

As described in this Amendment, the Policy is modified to provide Benefits for In Vitro Fertilization.

Because this Amendment reflects changes in requirements of insurance law of the State of Maryland, to the extent it 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 9: Defined Terms.

Section 1: Covered Health Services

In Vitro Fertilization in the Certificate, Section 1: Covered Health Services is replaced with the following:

In Vitro Fertilization

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

This Benefit is available if:

• For a patient whose spouse is of the opposite sex, the patient's oocytes are fertilized with the sperm of the patient's spouse.

• The patient and the patient's spouse have a history of involuntary infertility which may be demonstrated by a history of:
  ▪ The patient and the patient's spouse are of the opposite sexes and intercourse of at least two years duration has failed to result in Pregnancy; or
  ▪ The patient and the patient's spouse are of the same sex and six attempts of artificial insemination over the course of two years has failed to result in Pregnancy; or

• The diagnosis of infertility associated with any of the following medical conditions:
  ▪ Endometriosis,
  ▪ Exposure before birth to diethylstilbestrol, commonly known as DES,
  ▪ Blockage of or surgical removal of one or both fallopian tubes, or
  ▪ Abnormal male factors, including oligospermia, contributing to the infertility.

• The patient has been unable to attain a successful Pregnancy through less costly infertility treatments covered under the Policy.

• The in vitro fertilization procedures are performed at medical facilities that conform to the applicable guidelines or minimum standards issued by the American College of Obstetricians and Gynecologists guidelines for in vitro fertilization clinics, the American Fertility Society minimal standards for programs of in vitro fertilization, or the American Society for Reproductive Medicine.

See Schedule of Benefits for Benefit conditions and maximum Benefit.
UNITEDHEALTHCARE INSURANCE COMPANY

Jeffrey Alter, President
Virtual Visit and Pharmaceutical Product Amendment

UnitedHealthcare Insurance Company

As described in this Amendment, the Policy is modified as stated below, through the following changes to the Certificate of Coverage (Certificate) and Schedule of Benefits.

Section 1: Covered Health Services

1. The following provision is added to the Certificate, Section 1: Covered Health Services:

Virtual Visits

Virtual visits for Covered Health Services that include the diagnosis and treatment of low acuity medical conditions for Covered Persons through the use of interactive audio and video telecommunication and transmissions, and audio-visual communication technology. Virtual visits provide communication of medical information in real-time between the patient and a distant Physician or health specialist, through use of interactive audio and video communications equipment outside of a medical facility (for example, from home or from work).

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

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

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

Schedule of Benefits

1. The provision below for Virtual Visits is added to the Schedule of Benefits.

<table>
<thead>
<tr>
<th>Covered Health Service</th>
<th>Benefit (The Amount We Pay, based on Eligible Expenses)</th>
<th>Apply to the Out-of-Pocket Maximum?</th>
<th>Must You Meet Annual Deductible?</th>
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</thead>
<tbody>
<tr>
<td>Virtual Visits</td>
<td>Network 100%</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Non-Network</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to www.myuhc.com or by calling Customer Care at the telephone number on your ID card.
Section 2: Exclusions and Limitations

1. The exclusion for New Pharmaceutical Product in the Certificate under Section 2: Exclusions and Limitations, D. Drugs is replaced with the following:

New Pharmaceutical Products and/or new dosage forms until the date they are reviewed. However, we will provide immediate coverage for a New Pharmaceutical Product if, in the judgment of the authorized prescriber (as defined in Section 12-101 of the Health Occupation Article of the Maryland Code):

- There is no equivalent Pharmaceutical Product on the Pharmaceutical Product List; or
- An equivalent Pharmaceutical Product on the Pharmaceutical Product List:
  - Has been ineffective in treating a Covered Person's disease or condition; or
  - Has caused or is likely to cause an adverse reaction or other harm to the Covered Person.

2. The following exclusions for Pharmaceutical Products are added in the Certificate under Section 2: Exclusion and Limitations, D. Drugs:

A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year. However, we will provide immediate coverage for a Pharmaceutical Product deemed therapeutically equivalent if, in the judgment of the authorized prescriber (as defined in Section 12-101 of the Health Occupation Article of the Maryland Code):

- The excluded Pharmaceutical Product is not therapeutically equivalent to the other covered Pharmaceutical Products; or
- The covered Pharmaceutical Product on the Pharmaceutical Product List:
  - Has been ineffective in treating a Covered Person's disease or condition; or
  - Has caused or is likely to cause an adverse reaction or other harm to the Covered Person.

A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year. However, we will provide immediate coverage for a Pharmaceutical Product deemed therapeutically equivalent if, in the judgment of the authorized prescriber (as defined in Section 12-101 of the Health Occupation Article of the Maryland Code):

- The excluded Pharmaceutical Product is not therapeutically equivalent to the other covered Pharmaceutical Products; or
- The covered Pharmaceutical Product on the Pharmaceutical Product List:
  - Has been ineffective in treating a Covered Person's disease or condition; or

<table>
<thead>
<tr>
<th>Covered Health Service</th>
<th>Benefit (The Amount We Pay, based on Eligible Expenses)</th>
<th>Apply to the Out-of-Pocket Maximum?</th>
<th>Must You Meet Annual Deductible?</th>
</tr>
</thead>
<tbody>
<tr>
<td>80%</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
• Has caused or is likely to cause an adverse reaction or other harm to the Covered Person.

Section 9: Defined Terms

1. The following definition of Designated Virtual Network Provider is added to the Certificate under Section 9: Defined Terms:

Designated Virtual Network Provider - a provider or facility that has entered into an agreement with us, or with an organization contracting on our behalf, to deliver Covered Health Services via interactive audio and video modalities.

UNITEDHEALTHCARE INSURANCE COMPANY

[Signature]

Jeffrey Alter, President
Outpatient Prescription Drug
UnitedHealthcare Insurance Company
Schedule of Benefits

Benefits for Prescription Drug Products
Benefits are available for Prescription Drug Products at either a Network Pharmacy or a non-Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service.

Benefits for Oral Chemotherapeutic Agents
Oral chemotherapeutic agent Prescription Drug Products will be provided at a level no less favorable than chemotherapeutic agents are provided under Pharmaceutical Products - Outpatient in your Certificate of Coverage, regardless of tier placement.

If a Brand-name Drug Becomes Available as a Generic
If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change. You will pay the Copayment and/or Coinsurance 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 and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, 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). 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 or Coinsurance for the supply that exceeds the limit. You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at www.myuhc.com or by calling Customer Care at the telephone number on your ID card.

Prior Authorization Requirements
Before certain Prescription Drug Products are dispensed to you, either your Physician, your pharmacist or you are required to obtain prior authorization from us or our designee. The reason for obtaining prior authorization from us is to determine whether the Prescription Drug Product, in accordance with our approved guidelines, is each of the following:
• It meets the definition of a Covered Health Service.
• It is not an Experimental or Investigational or Unproven Service.

**Network Pharmacy Prior Authorization**

When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for obtaining prior authorization from us.

**Non-Network Pharmacy Prior Authorization**

When Prescription Drug Products are dispensed at a non-Network Pharmacy, you or your Physician are responsible for obtaining prior authorization from us as required.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you may pay more for that Prescription Order or Refill. The Prescription Drug Products requiring prior authorization are subject to our periodic review and modification. You may determine whether a particular Prescription Drug Product requires prior authorization through the Internet at www.myuhc.com or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. The pharmacy will require you to pay for the Prescription Drug Product at the pharmacy. Our contracted pharmacy reimbursement rates (our Prescription Drug Charge) will not be available to you at a non-Network Pharmacy. You may seek reimbursement from us as described in the Certificate of Coverage (Certificate) in Section 5: How to File a Claim.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge (for Prescription Drug Products from a Network Pharmacy) or the Predominant Reimbursement Rate (for Prescription Drug Products from a non-Network Pharmacy), less the required Copayment and/or Coinsurance, 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 an Experimental or Investigational or Unproven Service.

**Step Therapy**

Certain Prescription Drug Products for which Benefits are described under this Prescription Drug Rider or Pharmaceutical Products for which Benefits are described in your Certificate are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

A step therapy requirement may not be imposed if:

• The step therapy drug has not been approved by the U.S. Food and Drug Administration (FDA) for the medical condition being treated; or

• The prescribing provider documents and notifies us that a Prescription Drug Product:
  • Was ordered by the prescribing provider for the Covered Person within the past 180 days; and
  • Based on the professional judgment of the prescribing provider, was effective in treating the Covered Person’s medical condition.
You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at www.myuhc.com or by calling Customer Care at the telephone number on your ID card.

**What You Must Pay**

You must incur expenses equal to the Annual Deductible stated in the *Schedule of Benefits* which is attached to your *Certificate* before Benefits for Prescription Drug Products under this Rider are available to you.

You must incur expenses equal to the applicable Copayment and/or Coinsurance described in the Benefit Information table.

The amount you must incur for any of the following under this Rider will not be included in calculating any Out-of-Pocket Maximum stated in your *Certificate*:

- The difference between the Predominant Reimbursement Rate and a non-Network Pharmacy’s Usual and Customary Charge for a Prescription Drug Product.
- Any non-covered drug product. You must incur expenses equal to 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.
### Payment Information

<table>
<thead>
<tr>
<th>Payment Term And Description</th>
<th>Amounts</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Copayment and Coinsurance</strong></td>
<td>For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of the following:</td>
</tr>
<tr>
<td><strong>Copayment</strong></td>
<td>• The applicable Copayment and/or Coinsurance.</td>
</tr>
<tr>
<td>Copayment for a Prescription Drug Product at a Network or non-Network Pharmacy is a specific dollar amount.</td>
<td>• The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product.</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts.</td>
</tr>
<tr>
<td>Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge.</td>
<td>Your Copayment and/or Coinsurance will never exceed the retail price of the Prescription Drug Product.</td>
</tr>
<tr>
<td>Coinsurance for a Prescription Drug Product at a non-Network Pharmacy is a percentage of the Predominant Reimbursement Rate.</td>
<td></td>
</tr>
<tr>
<td><strong>Copayment and Coinsurance</strong></td>
<td></td>
</tr>
<tr>
<td>Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product.</td>
<td></td>
</tr>
<tr>
<td>We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance if the combination of these multiple products provides a therapeutic treatment regimen that is supported by available clinical evidence. You may determine whether a therapeutic treatment regimen qualifies for a single Copayment and/or Coinsurance through the Internet at <a href="http://www.myuhc.com">www.myuhc.com</a> or by calling Customer Care at the telephone number on your ID card.</td>
<td></td>
</tr>
<tr>
<td>Your Copayment and/or Coinsurance may be reduced when you participate in certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on these programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at</td>
<td></td>
</tr>
<tr>
<td>Payment Term And Description</td>
<td>Amounts</td>
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</tr>
<tr>
<td><a href="http://www.myuhc.com">www.myuhc.com</a> or by calling Customer Care at the telephone number on your ID card.</td>
<td></td>
</tr>
<tr>
<td><strong>Special Programs</strong>: We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at <a href="http://www.myuhc.com">www.myuhc.com</a> or by calling Customer Care at the telephone number on your ID card.</td>
<td></td>
</tr>
<tr>
<td><strong>Copayment/Coinsurance Waiver Program</strong>: If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills.</td>
<td></td>
</tr>
<tr>
<td><strong>Prescription Drug Products Prescribed by a Specialist Physician</strong>: You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at <a href="http://www.myuhc.com">www.myuhc.com</a> or by calling Customer Care at the telephone number on your ID card.</td>
<td></td>
</tr>
<tr>
<td><strong>NOTE</strong>: 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 (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access</td>
<td></td>
</tr>
<tr>
<td>Payment Term And Description</td>
<td>Amounts</td>
</tr>
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<td>---------------------------------------------------------------------------------------------</td>
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<tr>
<td><a href="http://www.myuhc.com">www.myuhc.com</a> through the Internet or call Customer Care at the telephone number on your ID card for the most up-to-date tier status.</td>
<td></td>
</tr>
<tr>
<td><strong>Coupons:</strong> We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at <a href="http://www.myuhc.com">www.myuhc.com</a> or by calling Customer Care at the telephone number on your ID card.</td>
<td></td>
</tr>
</tbody>
</table>
## Benefit Information

<table>
<thead>
<tr>
<th>Description and Supply Limits</th>
<th>Benefit (The Amount We Pay)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Specialty Prescription Drug Products</strong></td>
<td><strong>Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Specialty Prescription Drug Product. All Specialty Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2 or Tier 3. Please access <a href="http://www.myuhc.com">www.myuhc.com</a> through the Internet or call Customer Care at the telephone number on your ID card to determine tier status.</strong></td>
</tr>
<tr>
<td>The following supply limits apply.</td>
<td><strong>Network Pharmacy</strong></td>
</tr>
<tr>
<td>• As written by the provider, up to a consecutive 31-day supply of a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer’s packaging size, or based on supply limits.</td>
<td>For a Tier 1 Specialty Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $10.00 per Prescription Order or Refill.</td>
</tr>
<tr>
<td></td>
<td>For a Tier 2 Specialty Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $30.00 per Prescription Order or Refill.</td>
</tr>
<tr>
<td></td>
<td>For a Tier 3 Specialty Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $50.00 per Prescription Order or Refill.</td>
</tr>
<tr>
<td></td>
<td><strong>Non-Network Pharmacy</strong></td>
</tr>
<tr>
<td>• When a Specialty Prescription Drug Product is classified as a Maintenance Medication according to Maryland law and as confirmed by the provider:</td>
<td>For a Tier 1 Specialty Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of $10.00 per Prescription Order or Refill.</td>
</tr>
<tr>
<td></td>
<td>However, you will not pay more than $150 per 30-day supply for a Specialty Prescription Drug Product Prescription Order or Refill.</td>
</tr>
<tr>
<td></td>
<td>For a Tier 2 Specialty Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of $30.00 per Prescription Order or Refill.</td>
</tr>
<tr>
<td></td>
<td>For a Tier 3 Specialty Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of $50.00 per Prescription Order or Refill.</td>
</tr>
<tr>
<td>• Up to a consecutive 31-day supply for a new prescription or a change in prescription of a Specialty Prescription Drug Product; and</td>
<td>For a Tier 1 Specialty Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of $10.00 per Prescription Order or Refill.</td>
</tr>
<tr>
<td>• Thereafter, up to a consecutive 90-day supply of a Specialty Prescription Drug Product subject to a Copayment and/or Coinsurance up to 2 times the Copayment and/or Coinsurance for a 31-day supply.</td>
<td>However, you will not pay more than $150 per 30-day supply for a Specialty Prescription Drug Product Prescription Order or Refill.</td>
</tr>
<tr>
<td>• When a Specialty Prescription Drug Product is a covered prescription eye drop medication, Benefits will be provided for early eye drop refills, in accordance with guidance for early refill of topical ophthalmic product provided to Medicare Part D plan sponsors by the Centers for Medicare and Medicaid; and if: 1) 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</td>
<td>For a Tier 1 Specialty Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of $10.00 per Prescription Order or Refill.</td>
</tr>
<tr>
<td></td>
<td>For a Tier 2 Specialty Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of $30.00 per Prescription Order or Refill.</td>
</tr>
<tr>
<td></td>
<td>For a Tier 3 Specialty Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of $50.00 per Prescription Order or Refill.</td>
</tr>
<tr>
<td>Description and Supply Limits</td>
<td>Benefit (The Amount We Pay)</td>
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<tr>
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<tr>
<td>does not exceed the number of additional quantities indicated on the original Prescription Order or Refill. When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed. Supply limits apply to Specialty Prescription Drug Products obtained at a Network Pharmacy, a non-Network Pharmacy, a mail order pharmacy or a Designated Pharmacy.</td>
<td>Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) 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 <a href="http://www.myuhc.com">www.myuhc.com</a> through the Internet or call Customer Care at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $10.00 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $30.00 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $50.00 per Prescription Order or Refill.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prescription Drugs from a Retail or mail order Network Pharmacy</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>The following supply limits apply:</td>
<td>Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) 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 <a href="http://www.myuhc.com">www.myuhc.com</a> through the Internet or call Customer Care at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $10.00 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $30.00 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $50.00 per Prescription Order or Refill.</td>
</tr>
<tr>
<td>- 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.</td>
<td></td>
</tr>
<tr>
<td>- As written by the provider, up to three cycles of an oral contraceptive at one time subject to a separate Copayment and/or Coinsurance for each cycle supplied.</td>
<td></td>
</tr>
<tr>
<td>- When a Prescription Drug Product is classified as a Maintenance Medication according to Maryland law and as written by the provider:</td>
<td></td>
</tr>
<tr>
<td>- Up to a consecutive 31-day supply for a new prescription or a change in prescription of a Prescription Drug Product; and</td>
<td></td>
</tr>
<tr>
<td>- Thereafter, up to a consecutive 90-day supply of a Prescription Drug Product subject to a</td>
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</tr>
</tbody>
</table>
### Description and Supply Limits

<table>
<thead>
<tr>
<th>Benefit (The Amount We Pay)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copayment and/or Coinsurance up to 2 times the Copayment and/or Coinsurance for a 31-day supply.</td>
</tr>
<tr>
<td>- When a Prescription Drug Product is a covered prescription eye drop medication, Benefits will be provided for early eye drop refills, in accordance with guidance for early refill of topical ophthalmic product provided to <em>Medicare Part D</em> plan sponsors by the <em>Centers for Medicare and Medicaid</em>; and if: 1) the prescribing Physician indicates on the original Prescription Order or Refill that additional quantities of the prescription eye drops are needed and; 2) the refill requested by the Covered Person does not exceed the number of additional quantities indicated on the original Prescription Order or Refill.</td>
</tr>
<tr>
<td>When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.</td>
</tr>
</tbody>
</table>

### Prescription Drugs from a Retail or Mail Order Non-Network Pharmacy

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.
- As written by the provider, up to three cycles of an oral contraceptive at one time subject to a separate Copayment and/or Coinsurance for each cycle supplied.
- When a Prescription Drug Product is a covered prescription eye drop medication, Benefits will be provided for early eye drop refills, in accordance with guidance for early refill of topical ophthalmic product provided to *Medicare Part D* plan sponsors by the *Centers for Medicare and Medicaid*; and if: 1) the prescribing Physician indicates on the original Prescription Order or Refill that additional quantities of the prescription eye drops are needed and; 2) the refill requested by the Covered Person does not exceed the number of additional quantities indicated on the original Prescription Order or Refill.

Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) 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 *Customer Care* at the telephone number on your ID card to determine tier status.

For a Tier 1 Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of $10.00 per Prescription Order or Refill.

For a Tier 2 Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of $30.00 per Prescription Order or Refill.
<table>
<thead>
<tr>
<th>Description and Supply Limits</th>
<th>Benefit (The Amount We Pay)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Product is classified as a Maintenance Medication according to Maryland law and as written by the provider:</td>
<td>For a Tier 3 Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of $50.00 per Prescription Order or Refill.</td>
</tr>
<tr>
<td>▪ Up to a consecutive 31-day supply for a new prescription or a change in prescription of a Prescription Drug Product; and</td>
<td></td>
</tr>
<tr>
<td>▪ Thereafter, up to a consecutive 90-day supply of a Prescription Drug Product subject to a Copayment and/or Coinsurance up to 2 times the Copayment and/or Coinsurance for a 31-day supply.</td>
<td></td>
</tr>
<tr>
<td>▪ When a Prescription Drug Product is a covered prescription eye drop medication, Benefits will be provided for early eye drop refills, in accordance with guidance for early refill of topical ophthalmic product provided to Medicare Part D plan sponsors by the Centers for Medicare and Medicaid; and if: 1) the prescribing Physician indicates on the original Prescription Order or Refill that additional quantities of the prescription eye drops are needed and; 2) the refill requested by the Covered Person does not exceed the number of additional quantities indicated on the original Prescription Order or Refill.</td>
<td></td>
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</tbody>
</table>

When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.
Outpatient Prescription Drug Rider

UnitedHealthcare Insurance Company

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

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in either the Certificate of Coverage (Certificate) in Section 9: Defined Terms or in this Rider in Section 3: Defined Terms.

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company. When we use the words "you" and "your" we are referring to people who are Covered Persons, as the term is defined in the Certificate in Section 9: Defined Terms.

NOTE: The Coordination of Benefits provision in the Certificate in Section 7: Coordination of Benefits applies to Prescription Drug Products covered through this Rider. Benefits for Prescription Drug Products will be coordinated with those of any other health plan in the same manner as Benefits for Covered Health Services described in the Certificate.

UNITEDHEALTHCARE INSURANCE COMPANY

Jeffrey Alter, President
Introduction

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 certain supply limits or prior authorization 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 Customer Care at the telephone 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 in 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 Charge, less the required Copayment and/or Coinsurance and any deductible that applies.

Submit your claim to the Pharmacy Benefit Manager claims address noted on your ID card.

Designated Pharmacies

If you require certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, you will be subject to the non-Network Benefit for that Prescription Drug Product.
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 31 days of the date we notify you, we will select a single Network Pharmacy for you. Benefits will continue to be available from a non-Network Pharmacy, however, such Benefits will not be paid at the Network Pharmacy Benefit level.

Rebates and Other Payments

We may receive rebates for certain drugs included on the Prescription Drug List. We do not pass these rebates on to you, nor are they applied to the combined medical and pharmacy Annual Deductible stated in the Schedule of Benefits attached to your Certificate or taken into account in determining your Copayments and/or Coinsurance.

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 do not pass on to you, such amounts.
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Section 1: Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at either a Network Pharmacy or a non-Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed. Refer to the Outpatient Prescription Drug Schedule of Benefits for applicable Copayments and/or Coinsurance requirements.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service.

Benefits are available for refills of Prescription Drug Products only when dispensed as ordered by a duly licensed health care provider and only after 3/4 of the original Prescription Drug Product has been used. However, when a Prescription Drug Product is a covered prescription eye drop medication, Benefits will be provided for early eye drop refills, in accordance with guidance for early refill of topical ophthalmic product provided to Medicare Part D plan sponsors by the Centers for Medicare and Medicaid; and if: 1) the prescribing Physician indicates on the original Prescription Order or Refill that additional quantities of the prescription eye drops are needed and; 2) the refill requested by the Covered Person does not exceed the number of additional quantities indicated on the original prescription order or refill.

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

If you require Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Specialty Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Specialty Prescription Drug Product from a Designated Pharmacy, you will be subject to the non-Network Benefit for that Specialty Prescription Drug Product.

Please see Section 3: Defined Terms for a full description of Specialty Prescription Drug Product and Designated Pharmacy.

Refer to the Outpatient Prescription Drug Schedule of Benefits for details on Specialty Prescription Drug Product supply limits.

Prescription Drugs for Smoking Cessation

In accordance with state law, we provide Benefits for Prescription Drug Products when prescribed by an Authorized Prescriber for:

- Any Prescription Drug Product that is approved by the U.S. Food and Drug Administration (FDA) as an aid for the cessation of the use of tobacco products; and
- Any Prescription Drug Product defined as Nicotine Replacement Therapy limited to two 90-day courses of treatment per calendar year.

Prescription Drugs from a Retail Network Pharmacy

Benefits are provided for Prescription Drug Products dispensed by a retail Network Pharmacy.

Refer to the Outpatient Prescription Drug Schedule of Benefits for details on retail Network Pharmacy supply limits.

Prescription Drugs from a Retail Non-Network Pharmacy

Benefits are provided for Prescription Drug Products dispensed by a retail non-Network Pharmacy.
If the Prescription Drug Product is dispensed by a retail non-Network Pharmacy, the non-Network Pharmacy may require that you pay for the Prescription Drug Product at the time it is dispensed. In that case, should then file a claim for reimbursement with us, as described in Section 5 of your Certificate of Coverage. We will not reimburse you for the difference between the Predominant Reimbursement Rate and the non-Network Pharmacy's Usual and Customary Charge for that Prescription Drug Product. We will not reimburse you for any non-covered drug product.

In most cases, you will pay more if you obtain Prescription Drug Products from a non-Network Pharmacy.

**Prescription Drug Products from a Mail Order Pharmacy**

Benefits are provided for certain Prescription Drug Products dispensed by a mail order pharmacy.

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on mail order pharmacy supply limits.

Please access www.myuhc.com through the Internet or call Customer Care at the telephone number on your ID card to determine if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order pharmacy.
Section 2: Exclusions

Exclusions from coverage listed in the Certificate apply also to this Rider, except that any preexisting condition exclusion in the Certificate is not applicable to this Rider. In addition, the exclusions listed below apply.

When an exclusion applies to only certain Prescription Drug Products, you can access www.myuhc.com through the Internet or call Customer Care at the telephone number on your ID card for information on which Prescription Drug Products are excluded.

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
4. Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
5. Experimental or 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 Prescription Drug Product if such Prescription Drug Product is recognized for treatment in any of the standard reference compendia or in the medical literature. Furthermore we shall provide Benefits for Prescription Drug Products that have been approved for sale by the U.S. Food and Drug Administration (FDA) whether or not the FDA has approved the Prescription Drug Product for use in treatment a particular condition, to the extent that the Prescription Drug Products are not paid for by the manufacturer, distributor, or provider of that Prescription Drug Product.
6. Prescription Drug Products furnished by the local, state or federal government. This exclusion does not apply 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 or weight loss.
9. A Pharmaceutical Product for which Benefits are provided in your Certificate of Coverage.
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 or repackagers of Prescription Drug Products.
13. Medications used for cosmetic purposes.
14. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of 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 prevent conception, including, but not limited to, oral contraceptives, diaphragms, Depo Provera and other injectable drugs used for contraception as defined in Section 3 under Prescription Drug Product.

17. Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration (FDA) and requires a Prescription Order or Refill. Compounded drugs that contain a non-FDA approved bulk chemical. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier 3.)

- However, we will provide immediate coverage for a compounded Prescription Drug Product if, in the judgment of the Authorized Prescriber:
  - There is no equivalent Prescription Drug Products on the Prescription Drug List; or
  - An equivalent Prescription Drug Product on the Prescription Drug List:
    - Has been ineffective in treating a Covered Person's disease or condition; or
    - Has caused or is likely to cause an adverse reaction or other harm to the Covered Person.

18. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that we have determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision. This exclusion does not apply to over-the-counter drugs used for smoking cessation. Please access www.myuhc.com through the Internet or call Customer Care at the telephone number on your ID card for information on which over-the-counter drugs are excluded.

Note: Notwithstanding this exclusion, we will provide immediate coverage for excluded Prescription Drug Products described above if, in the judgment of the Authorized Prescriber:

- The over-the-counter drug is not equivalent to the Prescription Drug Product on the Prescription Drug List; or
- An equivalent over-the-counter drug:
  - Has been ineffective in treating a Covered Person's disease or condition; or
  - Has caused or is likely to cause an adverse reaction or other harm to the Covered Person.

19. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by our PDL Management Committee. However, we will provide immediate coverage for a New Prescription Drug Product if, in the judgment of the Authorized Prescriber:

- There is no equivalent Prescription Drug Product on the Prescription Drug List; or
- An equivalent Prescription Drug Products on the Prescription Drug List:
  - Has been ineffective in treating a Covered Person's disease or condition; or
  - Has caused or is likely to cause an adverse reaction or other harm to the Covered Person.
20. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).

21. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, except as required by Maryland state mandate. (See definition of Prescription Drug Product below).

22. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision. Please access www.myuhc.com through the Internet or call Customer Care at the telephone number on your ID card for information on which Prescription Drug Products classified as Therapeutic Equivalent.

Note: We will provide immediate coverage for a Prescription Drug Product deemed Therapeutically Equivalent if, in the judgment of the Authorized Prescriber:

- The excluded Prescription Drug Product is not Therapeutically Equivalent to the other covered Prescription Drug Product; or
- The covered Prescription Drug Product on the Prescription Drug List:
  - Has been ineffective in treating a Covered Person's disease or condition; or
  - Has caused or is likely to cause an adverse reaction or other harm to the Covered Person.

23. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision. Please access www.myuhc.com through the Internet or call Customer Care at the telephone number on your ID card for information on which Prescription Drug Products classified as Therapeutic Equivalent.

Note: We will provide immediate coverage for a Prescription Drug Product deemed Therapeutically Equivalent if, in the judgment of the Authorized Prescriber:

- The excluded Prescription Drug Product is not Therapeutically Equivalent to the other covered Prescription Drug Product; or
- The covered Prescription Drug Product on the Prescription Drug List:
  - Has been ineffective in treating a Covered Person's disease or condition; or
  - Has caused or is likely to cause an adverse reaction or other harm to the Covered Person.


25. Dental products, including but not limited to prescription fluoride topicals.
Section 3: Defined Terms

**Authorized Prescriber** - has the meaning stated in Section 12-101 of the Health Occupation Article of the Maryland Code.

**Brand-name** - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that we identify as a Brand-name product, based on available data resources including, but not limited to, data sources such as medi-span or 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.

**Chemically Equivalent** - when Prescription Drug Products contain the same active ingredient.

**Designated Pharmacy** - a pharmacy that has entered into an agreement with us or with an organization contracting on our behalf, to provide specific Prescription Drug Products, including, but not limited to, Specialty Prescription 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, data sources such as medi-span or 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.

**Infertility** - failure to achieve a Pregnancy after a year of regular unprotected intercourse if the woman is under age 35, or after six months if the woman is over age 35. In addition, in order to be eligible for Benefits, the Covered Person must also:

- Be under age 44, if female.
- Have infertility that is not related to voluntary sterilization or failed reversal of voluntary sterilization.

**Maintenance Medication** - A Prescription Drug Product anticipated to be used for six months or more to treat a chronic condition. You may determine whether a Prescription Drug Product is a Maintenance Medication through the Internet at www.myuhc.com or by calling Customer Care at the telephone number on your ID card.

**Network Pharmacy** - a pharmacy that has:

- Entered into an agreement with us or an organization contracting on our behalf to provide Prescription Drug Products to Covered Persons; and
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products; and
- Been designated by us as a Network Pharmacy.

**New Prescription Drug Product** - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the U.S. Food and Drug Administration (FDA) and ending on the earlier of the following dates:

- The date it is assigned to a tier by our PDL Management Committee.
- December 31st of the following calendar year.

**Nicotine Replacement Therapy** - a Prescription Drug Product that:

- Is used to deliver nicotine to an individual attempting to cease the use of tobacco products;
• Is obtained under a prescription written by an Authorized Prescriber; and
• Does not include any over-the-counter product that may be obtained without a prescription.

**PPACA** - Patient Protection and Affordable Care Act of 2010.

**Predominant Reimbursement Rate** - the amount we will pay to reimburse you for a Prescription Drug Product that is dispensed at a non-Network Pharmacy. The Predominant Reimbursement Rate for a particular Prescription Drug Product dispensed at a non-Network Pharmacy includes a dispensing fee and any applicable sales tax. We calculate the Predominant Reimbursement Rate using our Prescription Drug Charge that applies for that particular Prescription Drug Product at most Network Pharmacies.

**Prescription Drug Charge** - the rate we have agreed to pay our Network Pharmacies, including the applicable dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

**Prescription Drug List** - a list that categorizes into tiers medications, products or devices that have been approved by the **U.S. Food and Drug Administration (FDA)**. 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 **Customer Care** at the telephone number on your ID card.

**Prescription Drug List (PDL) 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 **U.S. Food and Drug Administration (FDA)** 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; and
  • glucose monitors.

• In accordance with Maryland law, medical foods and low protein modified food products when prescribed and administered under the direction of a Physician for the treatment of inherited metabolic diseases caused by an inherited abnormality of body chemistry. See **Medical Foods** in **Section 1: Covered Health Services** in your **Certificate of Coverage** for more information.

• Contraceptive drugs or devices that are approved by the **U.S. Food and Drug Administration (FDA)** for use as a contraceptive and that are obtained under a prescription written by an Authorized Prescriber as defined in **Section 12-101 of the Maryland Health Occupations Article**.

**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.
**Specialty Prescription Drug Product** - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. Specialty Prescription Drug Products include certain drugs for Infertility. You may access a complete list of Specialty Prescription Drug Products through the Internet at www.myuhc.com or by calling Customer Care at the telephone number on your ID card.

**Therapeutically Equivalent** - when Prescription Drug Products have essentially the same efficacy and adverse effect profile.

**Usual and Customary Charge** - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax.
Important Notices under the Patient Protection and Affordable Care Act (PPACA)

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) and Schedule of Benefits. 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; laboratory services; maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; 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.

Please note that for plan years beginning on or after January 1, 2014, essential health benefits cannot be subject to annual or lifetime dollar limits.

- 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 at that time.

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, in-network 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.
  - With respect to women, such additional preventive care and screenings as provided for in 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.
Effective for policies that are new or renewing on or after January 1, 2014, the requirements listed below apply:

If your plan includes coverage for Clinical Trials, the following applies:

The clinical trial benefit has been modified to distinguish between clinical trials for cancer and other life threatening conditions and those for non-life threatening conditions. For trials for cancer/other life threatening conditions, routine patient costs now include those for covered individuals participating in a preventive clinical trial and Phase IV trials. This modification is optional for certain grandfathered health plans. Refer to your plan documents to determine if this modification has been made to your plan.

Pre-Existing Conditions:

Any pre-existing condition exclusions (including denial of benefit or coverage) will not apply to covered persons regardless of age.

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 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 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 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. If so, 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 your health plan ID card for assistance. 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 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. (http://www.dol.gov.ebsa/healthreform/ -click link for Consumer Assistance Programs)

For information on appeals and other PPACA regulations, visit www.healthcare.gov.

If your plan includes coverage for Mental Health or Substance Use, the following applies:

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.
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, Coinsurance 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 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, we will send you written notice of the decision from us within 15 days of receipt of the request. If you filed a pre-service request for Benefits improperly, we will notify you of the improper filing and how to correct it within five days after the pre-service request for Benefits was received. If additional information is needed to process the pre-service request, we will notify you of the information needed within 15 days after it was received, and may request a one time extension not longer than 15 days and pend your request until all information is received. Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, we will notify you of the determination within 15 days after the information is received. If you don’t provide the needed information within the 45-day period, your request for Benefits will be denied. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the appeal procedures.

If you have prescription drug Benefits and a retail or mail order pharmacy fails to fill a prescription that you have presented, you may file a pre-service health request for Benefits 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 Care department before requesting a formal appeal. If the Customer Care 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 Care representative. If you first informally contact our Customer Care department and later wish to request a formal appeal in writing, you should again contact Customer Care and request an appeal. If you request a formal appeal, a Customer Care 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 Care 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 through the submission of your appeal. 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. The decision to obtain the proposed treatment or procedure regardless of our decision is between you and your Physician.
Urgent Appeals that Require Immediate Action

Your appeal may require 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.
MEDICAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2015

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.

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 will comply with the requirements of applicable privacy laws relating to notifying you in the event of a breach of your health information.

We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, we will provide you, in our next annual distribution, either a revised notice or information about the material change and how to obtain a revised notice. We will provide you with this information either by direct mail or electronically in accordance with applicable law. In all cases, we will post the revised notice on your health plan website such as www.myuhc.com or www.uhcwest.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.

UnitedHealth Group collects and maintains oral, written and electronic information to administer our business and to provide products, services and information of importance to our enrollees. We maintain physical, electronic and procedural security safeguards in the handling and maintenance of our enrollee’s information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction or misuse.
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 Underwriting Purposes.** We may use or disclose your health information for underwriting purposes; however, we will not use or disclose your genetic information for such purposes.

- **For Reminders.** We may use or disclose health information to send you reminders about your benefits or care, such as appointment reminders with providers who provide medical care to you.

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. Special rules apply regarding when we may disclose health information to family members and others involved in a deceased individual's care. We may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.
For Public Health Activities such as reporting or preventing disease outbreaks to a public health authority.

For Reporting Victims of Abuse, Neglect or Domestic Violence to government authorities that are authorized by law to receive such information, including a social service or protective service agency.

For Health Oversight Activities to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.

For Judicial or Administrative Proceedings such as in response to a court order, search warrant or subpoena.

For Law Enforcement Purposes. We may disclose your health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.

To Avoid a Serious Threat to Health or Safety to you, another person, or the public, by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.

For Specialized Government Functions such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.

For Workers’ Compensation as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.

For Research Purposes such as research related to the 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.

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:

1. HIV/AIDS;
2. Mental health;
3. Genetic tests;
♦ 4. Alcohol and drug abuse;
♦ 5. Sexually transmitted diseases and reproductive health information; and
♦ 6. 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 "Federal and State Amendments" document.

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. This includes, except for limited circumstances allowed by federal privacy law, not using or disclosing psychotherapy notes about you, selling your health information to others, or using or disclosing your health information for certain promotional communications that are prohibited marketing communications under federal law, without your written authorization. Once you give us authorization to release your health information, we cannot guarantee that the recipient to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. To find out where to mail your written authorization and how to revoke an authorization, contact the phone number listed on 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. In certain circumstances, we will accept your verbal request to receive confidential communications, however, we may also require you confirm your request in writing. In addition, any requests to 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 certain health information we maintain about you such as claims and case or medical management records. If we maintain your health information electronically, you will have the right to request that we send a copy of your health information in an electronic format to you. You can also request that we provide a copy of your information to a third party that you identify. In some cases you may receive a summary of this health information. You must make a written request to inspect and copy your health information or have your information sent to a third party. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information. If we deny your request, you may have the right to have the denial reviewed. We may charge a reasonable fee for any copies.

• **You have the right to ask to amend** certain health information we maintain about you such as claims and case or medical management records, if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. If we deny your request, you may have a statement of your disagreement added to your health information.
You have the right to receive an accounting of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) for treatment, payment, and health care operations purposes; (ii) to you or pursuant to your authorization; and (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require us to provide an accounting.

You have the right to a paper copy of this notice. You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You also may obtain a copy of this notice on your health plan website, such as www.myuhc.com or www.uhcwest.com.

Exercising Your Rights

Contacting your Health Plan. If you have any questions about this notice or want information about exercising your rights, please call the toll-free member phone number on your health plan ID card or you may contact the UnitedHealth Group Customer Call Center Representative at 1-866-633-2446 or TTY 711.

Submitting a Written Request. Mail to us your written requests to exercise any of your rights, including modifying or cancelling a confidential communication, for copies of your records, or requesting amendments to your record, 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.

PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2015

We2 are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information, other than health information, about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

Information We Collect

Depending upon the product or service you have with us, we may collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age, medical information and Social Security number;
- Information about your transactions with us, our affiliates or others, such as premium payment and claims history; and
- Information from a consumer reporting agency.

Disclosure of Information

We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law. For example, in the course of our general business practices, we may, as permitted by law, disclose any of the personal financial information that we collect about you without your authorization, to the following types of institutions:

- To our corporate affiliates, which include financial service providers, such as other insurers, and non-financial companies, such as data processors:
- To nonaffiliated companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations; and
- To nonaffiliated companies that perform services for us, including sending promotional communications on our behalf.

Confidentiality and Security

We maintain physical, electronic and procedural safeguards in accordance with applicable state and federal standards to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

Questions about this Notice

If you have any questions about this notice, please call the toll-free member phone number on your health plan ID card or contact the UnitedHealth Group Customer Call Center at 1-866-633-2446 or TTY 711.

2For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities listed in footnote 1, beginning on the first page of the Health Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliates: AmeriChoice Health Services, Inc.; DCG Resource Options, LLC; Dental
Benefit Providers, Inc.; HealthAllies, Inc.; MAMSI Insurance Resources, LLC; Managed Physical Network, Inc.; OneNet PPO, LLC; OptumHealth Care Solutions, Inc.; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; Spectera, Inc.; UMR, Inc.; Unison Administrative Services, LLC; United Behavioral Health; United Behavioral Health of New York I.P.A., 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.
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; and
- 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>
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<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>
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<tr>
<th>Genetic Information</th>
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<tr>
<td>We are not allowed to use genetic information for underwriting purposes.</td>
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### Summary of State Laws

<table>
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<tr>
<th>General Health Information</th>
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<td>We are allowed to disclose general health information only (1) under certain limited circumstances, and /or (2) to specific recipients.</td>
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<tr>
<th>HMOs must give enrollees an opportunity to approve or refuse disclosures, subject to certain exceptions.</th>
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<tr>
<td>KY</td>
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<th>You may be able to restrict certain electronic disclosures of such health information.</th>
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<tr>
<td>NC, NV</td>
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<th>We are not allowed to use health information for certain purposes.</th>
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<tr>
<td>CA, IA</td>
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<th>We will not use and/or disclose information regarding certain public assistance programs except for certain purposes.</th>
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<tr>
<td>MO, NJ, SD</td>
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<tr>
<th>Prescriptions</th>
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<tr>
<td>We are allowed to disclose prescription-related information only (1) under certain limited</td>
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<tr>
<td>ID, NH, NV</td>
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<tr>
<td>Category</td>
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<td>----------------------------------------------------</td>
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<tr>
<td><strong>Communicable Diseases</strong></td>
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<tr>
<td><strong>Sexually Transmitted Diseases and Reproductive Health</strong></td>
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<tr>
<td><strong>Alcohol and Drug Abuse</strong></td>
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<td><strong>Genetic Information</strong></td>
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<td><strong>HIV / AIDS</strong></td>
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<td><strong>Mental Health</strong></td>
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<td>Certain restrictions apply to the use of mental health information.</td>
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<tr>
<td><strong>Child or Adult Abuse</strong></td>
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<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>
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</tbody>
</table>

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 Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation rights. Review the Summary Plan Description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to 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: AIMS Health Plan Welfare Benefit Plan

Name, Address and Telephone Number of Plan Sponsor and Named Fiduciary:

AIMS Health Plan
890 Airport Park Road
#103
Glen Burnie, MD 21061
(410) 590-6590

The Plan Sponsor retains all fiduciary responsibilities with respect to the Plan except to the extent the Plan Sponsor has delegated or allocated to other persons or entities one or more fiduciary responsibilities with respect to the Plan.

Claims Fiduciary: UnitedHealthcare Insurance Company ("UnitedHealthcare," refer to your Certificate of Coverage for details on the legal entity that provides your coverage) is your Plan's Claims Fiduciary and has been delegated this responsibility by your Plan Sponsor. Your Claims Fiduciary has the authority to require eligible individuals to furnish it with information necessary for the proper administration of your Plan.

Employer Identification Number (EIN): 52-1642161

Plan Number: 501

Plan Year: January 1 through December 31

Type of Plan: Health care coverage plan

Name, Business Address, and Business Telephone Number of Plan Administrator:

AIMS Health Plan
890 Airport Park Road
#103
Glen Burnie, MD 21061
(410) 590-6590

Type of Administration of the Plan: Your Plan is fully insured. Benefits are provided under a group insurance contract entered into between your Plan Sponsor and UnitedHealthcare. Claims for benefits are sent to UnitedHealthcare. Your employer and UnitedHealthcare share responsibility for administering the plan.

UnitedHealthcare Insurance Company
185 Asylum Street
Hartford, CT 06103-0450
860-702-5000

Person designated as Agent for Service of Legal Process: Plan Administrator

Discretionary Authority of Plan Administrator and Other Plan Fiduciaries: The Plan Administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given deference and be legally
binding on all parties and subject to review by a legal authority only to the extent the decision was arbitrary and capricious.

**Source of Contributions and Funding under the Plan:** There are no contributions to the Plan. Any required employee contributions are used to partially reimburse the Plan Sponsor for Premiums under the Plan. Benefits under the Plan are funded by the payment of Premium required by the group Policy.

**Method of Calculating the Amount of Contribution:** Employee-required contributions to the Plan Sponsor are the employee’s share of costs as determined by Plan Sponsor. From time to time, the Plan Sponsor will determine the required employee contributions for reimbursement to the Plan Sponsor and distribute a schedule of such required contributions to employees.

**Qualified Medical Child Support Orders:** The Plan’s procedures for handling qualified medical child support orders are available without charge upon request to the Plan Administrator.

**Amendment or Termination of the Plan:** Your employer, as the Plan Sponsor, has the right to amend or terminate this Plan at any time. Note that the insurance contract, which is how benefits under the Plan are provided, is not necessarily the same as the Plan. As a result, termination of the insurance contract does not necessarily terminate the Plan.