UnitedHealthcare Choice Plus
UnitedHealthcare Insurance Company

Certificate of Coverage

For
the Health Savings Account (HSA) Plan 7PD
of
Educators Benefit Services, Inc.
Enrolling Group Number: 717578
Effective Date: January 1, 2013

Offered and Underwritten by
UnitedHealthcare Insurance Company
UnitedHealthcare Insurance Company
185 Asylum Street
Hartford, Connecticut 06103-3408
800-357-1371
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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. For facility services, these are Benefits for Covered Health Services that are provided at a Network facility under the direction of either a Network or non-Network Physician or other provider. Network Benefits include Physician services provided in a Network facility by a Network or a non-Network anesthesiologist, Emergency room Physician, consulting Physician, pathologist and radiologist. Emergency Health Services are always paid as Network Benefits.

**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.

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.

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

Pre-service Benefit Confirmation
We require notification before you receive certain Covered Health Services. In general, Network providers are responsible for notifying us before they provide these services to you. There are some Network Benefits, however, for which you are responsible for notifying us. Services for which you must provide pre-service notification are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for notifying us before you receive these services.

To notify us, call the telephone number for *Customer Care* on your ID card.

Covered Health Services which require pre-service notification:
• Ambulance - non-emergent air and ground.
• Coverage of Clinical Trials.
• Congenital heart disease surgery.
• Dental services - accidental.
• Durable Medical Equipment over $1,000.
• Home health care.
• Hospice care - inpatient.
• Hospital inpatient care - all scheduled admissions and maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery.
• Infertility services.
• In Vitro Fertilization.
• Reconstructive procedures.
• Rehabilitation services and Chiropractic Treatment - Chiropractic Treatment.
• Skilled Nursing Facility and Inpatient Rehabilitation Facility services.
• Therapeutics - only for the following services: dialysis.
• Transplants.

As we determine, if one or more alternative health services that meets the definition of a Covered Health Service in the Certificate of Coverage under Section 9: Defined Terms are clinically appropriate and equally effective for prevention, diagnosis or treatment of a Sickness, Injury, Mental Illness, substance abuse or their symptoms, we reserve the right to adjust Eligible Expenses for identified Covered Health Services based on defined clinical protocols. Defined clinical protocols shall be based upon nationally recognized scientific evidence and prevailing medical standards and analysis of cost-effectiveness. After you contact us for pre-service Benefit confirmation, we will identify the Benefit level available to you.

The process and procedures used to define clinical protocols and cost-effectiveness of a health service and a listing of services subject to these provisions (as 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.

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 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 notice 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.

**Mental Health and Substance Abuse Services**

Mental Health and Substance Abuse Services are not subject to the pre-service notification requirements described above. Instead, you must obtain prior authorization from the Mental Health/Substance Abuse
Designee before you receive Mental Health Services and Substance Abuse Services. You can contact the Mental Health/Substance Abuse Designee at the telephone number on your ID card.

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 Coordination

When we are notified as required, we will work with you to implement the Care Coordination 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 notification requirements described below 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 notify us 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>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductible</strong></td>
<td></td>
</tr>
<tr>
<td>The amount of Eligible Expenses you pay 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. The Annual Deductible 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.</td>
<td><strong>Network</strong> $2,500 per Covered Person, not to exceed $5,000 for all Covered Persons in a family. <strong>Non-Network</strong> $4,800 per Covered Person, not to exceed $9,600 for all Covered Persons in a family.</td>
</tr>
</tbody>
</table>

Amounts paid toward the Annual Deductible for Covered
### Payment Term And Description

<table>
<thead>
<tr>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
<tr>
<td>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 table.</td>
</tr>
</tbody>
</table>

### Out-of-Pocket Maximum

<table>
<thead>
<tr>
<th>The maximum you pay per year for the Annual Deductible, 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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Details about the way in which Eligible Expenses are determined appear at the end of the Schedule of Benefits table.</td>
</tr>
<tr>
<td>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:</td>
</tr>
<tr>
<td>Any charges for non-Covered Health Services.</td>
</tr>
<tr>
<td>The amount Benefits are reduced if you do not notify us as required.</td>
</tr>
<tr>
<td>Charges that exceed Eligible Expenses.</td>
</tr>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

### Maximum Policy Benefit

<table>
<thead>
<tr>
<th>The maximum amount we will pay for Benefits during the entire period of time you are enrolled under the Policy.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Network</strong></td>
</tr>
<tr>
<td>No Maximum Policy Benefit.</td>
</tr>
</tbody>
</table>

---

<table>
<thead>
<tr>
<th>Payment Term And Description</th>
<th>Amounts</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>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 table.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Out-of-Pocket Maximum</th>
<th>Amounts</th>
</tr>
</thead>
<tbody>
<tr>
<td>The maximum you pay per year for the Annual Deductible, 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.</td>
<td><strong>Network</strong></td>
</tr>
<tr>
<td>Details about the way in which Eligible Expenses are determined appear at the end of the Schedule of Benefits table.</td>
<td><strong>Network</strong></td>
</tr>
<tr>
<td>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:</td>
<td><strong>Network</strong></td>
</tr>
<tr>
<td>Any charges for non-Covered Health Services.</td>
<td><strong>Network</strong></td>
</tr>
<tr>
<td>The amount Benefits are reduced if you do not notify us as required.</td>
<td><strong>Network</strong></td>
</tr>
<tr>
<td>Charges that exceed Eligible Expenses.</td>
<td><strong>Network</strong></td>
</tr>
<tr>
<td>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.</td>
<td><strong>Network</strong></td>
</tr>
</tbody>
</table>

---

<table>
<thead>
<tr>
<th>Maximum Policy Benefit</th>
<th>Amounts</th>
</tr>
</thead>
<tbody>
<tr>
<td>The maximum amount we will pay for Benefits during the entire period of time you are enrolled under the Policy.</td>
<td><strong>Network</strong></td>
</tr>
<tr>
<td>No Maximum Policy Benefit.</td>
<td><strong>Network</strong></td>
</tr>
</tbody>
</table>
### Payment Term And Description | Amounts
--- | ---
**Non-Network** | No Maximum Policy Benefit.

**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.

**Coinsurance**

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.

### Benefit Limits

This Benefit plan does not have Benefit limits in addition to those stated below within the Covered Health Service categories in 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 100% No Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-Network 100% No Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Ambulance Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Pre-service Notification Requirement</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<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 notify us as soon as possible prior to transport. If you fail to notify us as required, you will be responsible for paying all charges and no Benefits will be paid.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Ambulance</td>
<td><strong>Network</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ground Ambulance:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Air Ambulance:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td><strong>Non-Network</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Same as Network</td>
<td>Same as Network</td>
<td>Same as Network</td>
</tr>
<tr>
<td>Non-Emergency Ambulance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Network</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ground Ambulance:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Air Ambulance:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td><strong>Non-Network</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Same as Network</td>
<td>Same as Network</td>
<td>Same as Network</td>
</tr>
<tr>
<td>3. Congenital Heart Disease Surgeries</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Pre-service Notification Requirement</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>For Non-Network Benefits you must notify us as soon as the possibility of a Congenital Heart Disease (CHD) surgery arises. If you don’t notify us, Benefits will be reduced to 50% of Eligible Expenses.</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>Network and Non-Network Benefits under this section include only 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. Non-Network Benefits are limited to $30,000 per CHD surgery.</td>
<td>Network 100%</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Non-Network 80%</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

4. Dental Services - Accident Only

**Pre-service Notification Requirement**

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

Limited to $3,000 per year. Benefits are further limited to a maximum of $900 per tooth.

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

5. Diabetes Services

**Pre-service Notification Requirement**

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

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

<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>Network</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 under this Covered Health Service.</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>
</table>
| Diabetes Self-Management Items | Non-Network  
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 under this Covered Health Service.  

Network  
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 Annual Maximum Drug Benefit shown in the Rider does not apply to Benefits for diabetes self-management items under this Covered Health Service.  

Non-Network  
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 Annual Maximum Drug Benefit shown in the Rider does not apply to Benefits for diabetes self-management items under this Covered Health Service. |

6. Durable Medical Equipment

<table>
<thead>
<tr>
<th>Pre-service Notification Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>For Non-Network Benefits you must notify us before obtaining any Durable Medical Equipment that exceeds $1,000 in cost (either purchase price or cumulative rental of a single item). If you fail to notify us as required, Benefits will be reduced to 50% of Eligible Expenses.</td>
</tr>
</tbody>
</table>

**Network**

| Limited to $7,500 in Eligible Expenses per year. Benefits are limited to a single purchase of a type of DME (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. |
| Network |
| 100% |
| No |
| 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 (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>7. Emergency Health Services - Outpatient</td>
<td>Non-Network</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Network</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Non-Network</td>
<td>Same as Network</td>
<td>Same as Network</td>
<td></td>
</tr>
<tr>
<td>8. Hearing Aids for Adults</td>
<td>Limited to $5,000 per year.</td>
<td>Network</td>
<td>100%</td>
</tr>
<tr>
<td>9. Home Health Care</td>
<td>Pre-service Notification Requirement</td>
<td>Network</td>
<td>100%</td>
</tr>
<tr>
<td>Limited to 200 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not apply to home health care in an acute inpatient setting for those with permanent disabilities.</td>
<td>Network</td>
<td>100%</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></td>
<td></td>
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</tr>
<tr>
<td>apply to the visits mandated by state law described in Section 1 of the Certificate of Coverage under Home Health Care. This visit limit does not include any service which is billed only for the administration of intravenous infusion.</td>
<td>Non-Network 80%</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Hospice Care</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Pre-service Notification Requirement</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>For Non-Network Benefits you must notify us five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. If you fail to notify us as required, Benefits will be reduced to 50% of Eligible Expenses.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>In addition, for Non-Network Benefits, you must contact us within 24 hours of admission for an Inpatient Stay in a hospice facility.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Network 100%</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Non-Network 80%</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>11. Hospital - Inpatient Stay</td>
<td>Pre-service Notification Requirement</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>For Non-Network Benefits for a scheduled admission, you must notify us five business days before admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). If you fail to notify us as required, Benefits will be reduced to 50% of Eligible Expenses.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>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).</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Network 100%</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Non-Network 80%</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
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<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>12. Infertility Services</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**Pre-service Notification Requirement**

You must notify us as soon as the possibility of the need for Infertility Services arises. If you fail to notify us 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.

**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.

<table>
<thead>
<tr>
<th>13. Lab, X-Ray and Diagnostics - Outpatient</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
</table>

**Network**

- 100%

**Non-Network**

- 80%

<table>
<thead>
<tr>
<th>14. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
</table>

**Network**

- 100%

**Non-Network**

- 80%

<table>
<thead>
<tr>
<th>15. Mental Health and Substance Abuse Services</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
</table>

**Inpatient Services**

**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>
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</tbody>
</table>

You must obtain prior authorization through the Mental Health/Substance Abuse Designee in order to receive Benefits. Without authorization, you will be responsible for paying all charges and no Benefits will be paid.

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

**Outpatient Services**

**Prior Authorization Requirement**

You must obtain prior authorization through the Mental Health/Substance Abuse Designee in order to receive Benefits. Without authorization, you will be responsible for paying all charges and no Benefits will be paid.

Intermediate Care Benefits in a Hospital or Alternate Facility are considered Outpatient Services and are covered on the same basis as outpatient services for physical illness limited to 60 days per year.

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

- Will not be counted against any visit limit; and
- Will be reimbursed under the same terms and conditions as an office visit for physical illness as shown below under *Physician's Office Services - Sickness and Injury* except that for medication management involving methadone treatment, any Copayment shall not exceed 50% of the daily cost of such treatment.

<table>
<thead>
<tr>
<th>Network</th>
<th>100%</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Network</td>
<td>80%</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
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<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>16. Ostomy Supplies</td>
<td>Network 100%</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Limited to $7,500 per year.</td>
<td>Non-Network 80%</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>17. Pharmaceutical Products - Outpatient</td>
<td>Network 100%</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Non-Network 80%</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>18. Physician Fees for Surgical and Medical Services</td>
<td>Network 100%</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Non-Network 80%</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>19. Physician's Office Services - Sickness and Injury</td>
<td>Network 100%</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Non-Network 80%</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>20. Pregnancy - Maternity Services</td>
<td>Network 100%</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Non-Network 80%</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Pre-service Notification Requirement

For Non-Network Benefits you must notify us 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 a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you fail to notify us 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
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><strong>Network</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>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>
<tr>
<td></td>
<td><strong>Non-Network</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>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>

21. Preventive Care Services

<table>
<thead>
<tr>
<th>Physician office services</th>
<th><strong>Network</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>100%</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td><strong>Non-Network</strong></td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lab, X-ray or other preventive tests</th>
<th><strong>Network</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>100%</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td><strong>Non-Network</strong></td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

22. Prosthetic Devices

Limited to $7,500 per year. 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.

<table>
<thead>
<tr>
<th></th>
<th><strong>Network</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>100%</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th><strong>Non-Network</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>80%</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
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<th>Apply to the Out-of-Pocket Maximum?</th>
<th>Must You Meet Annual Deductible?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>23. Reconstructive Procedures</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Pre-service Notification Requirement</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>For Non-Network Benefits you must notify us 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 notify us as required, Benefits will be reduced to 50% of Eligible Expenses.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>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).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Network</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<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 for reconstructive breast surgery under this Covered Health Service.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Non-Network</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<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 for reconstructive breast surgery under this Covered Health Service.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>24. Rehabilitation Services - Outpatient Therapy and Chiropractic Treatment</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Pre-service Notification Requirement</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>For Non-Network Benefits you must notify us five business days before receiving Chiropractic Treatment or as soon as is reasonably possible. If you fail to notify us as required, Benefits will be reduced to 50% of Eligible Expenses.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limited per year as follows:</td>
<td>Network</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>• 60 visits of physical therapy.</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 60 visits of occupational therapy.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 60 visits of Chiropractic</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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<th>Must You Meet Annual Deductible?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 60 visits of speech therapy.</td>
<td></td>
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</tr>
<tr>
<td>• 20 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>
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</tr>
<tr>
<td><strong>Note:</strong> Outpatient Rehabilitative Services received in connection with the Treatment of Cleft Lip or Cleft Palate or Both Benefit shown below under Additional Benefits Required by Maryland Law, are not subject to any visit or dollar limit shown above.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>25. Scopic Procedures - Outpatient Diagnostic and Therapeutic</strong></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>
<tr>
<td><strong>26. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Pre-service Notification Requirement</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>For Non-Network Benefits for a scheduled admission, you must notify us five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you fail to notify us as required, Benefits will be reduced to 50% of Eligible Expenses.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>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).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limited to 180 days per year.</td>
<td><strong>Network</strong></td>
<td></td>
<td></td>
</tr>
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<th>Must You Meet Annual Deductible?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>100%</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Non-Network</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>27. Surgery - Outpatient</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Non-Network</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>28. Therapeutic Treatments - Outpatient</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Network</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Non-Network</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>29. Transplantation Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Network</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>100%</td>
<td>No</td>
<td>Yes</td>
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<tr>
<td></td>
<td>Non-Network</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Pre-service Notification Requirement

For Non-Network Benefits you must notify us for the following outpatient therapeutic services five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. Services that require notification: dialysis. If you fail to notify us as required, Benefits will be reduced to 50% of Eligible Expenses.

Pre-service Notification Requirement

For Network Benefits you must notify us 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 notify us 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 notify us 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 notify us 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
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>Designated Facility. We do not require that cornea transplants be performed at a Designated Facility in order for you to receive Network Benefits. Non-Network Benefits are limited to $30,000 per transplant.</td>
<td><strong>100%</strong></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>
<tr>
<td><strong>30. Urgent Care Center Services</strong></td>
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</tr>
<tr>
<td>Network</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>
<tr>
<td><strong>31. Vision Examinations</strong></td>
<td></td>
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<tr>
<td>Limited to 1 exam per year.</td>
<td><strong>Network</strong></td>
<td>100%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Non-Network</strong></td>
<td>80%</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td><strong>Additional Benefits Required By Maryland Law</strong></td>
<td></td>
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<tr>
<td><strong>32. Bones of Face, Neck, and Head</strong></td>
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<tr>
<td>Notification Requirements</td>
<td>Depending upon where the Covered Health Service is provided, any applicable notification or authorization requirements will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.</td>
<td></td>
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<tr>
<td><strong>Network</strong></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><strong>Non-Network</strong></td>
<td>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under</td>
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<td>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>

33. Child Hearing Aid Coverage

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<thead>
<tr>
<th></th>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limit to $1,400 per hearing aid for each hearing impaired ear every 36 months. Any separate Annual Maximum Benefit shown in this Schedule does not apply.</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>Yes</td>
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<td></td>
<td>Yes</td>
<td>Yes</td>
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</table>

34. Child Wellness Services

<table>
<thead>
<tr>
<th></th>
<th>Network</th>
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<tbody>
<tr>
<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 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.</td>
<td></td>
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</tbody>
</table>

35. Treatment of Cleft Lip or Palate or Both

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<thead>
<tr>
<th></th>
<th>Notification Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depending upon where the Covered Health Service is provided, any applicable notification or authorization requirements will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.</td>
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<th>Network</th>
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**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.

### 36. Coverage for Clinical Trial Costs

**Pre-service Notification Requirement**

You must notify us as soon as reasonably possible after the possibility of participation in a clinical trial arises. If you don't notify us, 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.

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

**Notification Requirements**

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

**Network**
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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**Non-Network**

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38. Habilitative Services

**Notification Requirements**

Depending upon where the Covered Health Service is provided, any applicable notification or 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.

39. Hair Prosthesis

Limited to $350.

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

<table>
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<th>Apply to the Out-of-Pocket Maximum?</th>
<th>Must You Meet Annual Deductible?</th>
</tr>
</thead>
</table>

40. In Vitro Fertilization

**Pre-service Notification Requirement**

You must notify us as soon as reasonably possible after the need for In Vitro Fertilization Services arises. If you fail to notify us as required, Benefits will be reduced to 50% of Eligible Expenses.

Limited to three in vitro fertilization attempts per live birth, subject to a maximum benefit of $100,000 per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy. This limit includes Benefits for infertility medications provided under the Outpatient Prescription Drug Rider.

**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.

41. Medical Foods

<table>
<thead>
<tr>
<th>Network</th>
<th>100%</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
</table>

**Non-Network**

80% Yes Yes

42. Surgical Morbid Obesity Treatment

**Notification Requirements**

Depending upon where the Covered Health Service is provided, any applicable notification or 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
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>Benefits specific to such Covered Health Service category does not apply to Benefits under this Covered Health Service.</td>
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<td></td>
</tr>
</tbody>
</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.

**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. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the Certificate of Coverage.

If one or more alternative health services that meets the definition of Covered Health Service in the Certificate of Coverage under Section 9: Defined Terms are clinically appropriate and equally effective for prevention, diagnosis or treatment of a Sickness, Injury, Mental Illness, substance abuse or their symptoms, we reserve the right to adjust Eligible Expenses for identified Covered Health Services based on defined clinical protocols. Defined clinical protocols shall be based upon nationally recognized scientific evidence and prevailing medical standards and analysis of cost-effectiveness.

For Network Benefits, Eligible Expenses are based on either of 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 otherwise arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated.

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 the lesser of:
  - For Covered Health Services other than Pharmaceutical Products, Eligible Expenses are determined based on available data resources of competitive fees in that geographic area.
  - When Covered Health Services are Pharmaceutical Products, Eligible Expenses are determined based on 115% of the amount that the Centers for Medicare and Medicaid Services (CMS) would have paid under the Medicare program for the drug determined by either of the following:
    - Reference to available CMS schedules.
- Methods similar to those used by CMS.
  - Fee(s) that are negotiated with the provider.
  - 60% of the billed charge.
- 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. 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.
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.
- 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 the 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 the Certificate are related to other sections of the document. You may not have all of the information you need by reading just one section. We also encourage you to keep your Certificate and 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.

Pay Your Share

You must 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. 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. 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:

- 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 and/or any Maximum Policy Benefit).
- Any limit that applies to the amount you are required to pay in a year (Out-of-Pocket Maximum).
- Any responsibility you have for notifying us or obtaining prior authorization.

*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, when another method of pain management has failed.
- 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 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, but are not limited to, 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.

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. 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 the 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. Coverage is 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. If you rent or purchase a piece of Durable Medical Equipment that exceeds this guideline, you will be responsible for any cost difference between the piece you rent or purchase and the piece we have determined is the most cost-effective.

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).
• 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.
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).
Benefits under this section are not available for services to treat a condition that does not meet the
definition of an Emergency.

8. Hearing Aids for Adults
Hearing aids which are 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.

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 patient who received less than 48 hours of inpatient hospitalization following a mastectomy or the surgical removal of a testicle, or who undergoes such procedures on an outpatient basis. We will provide coverage for an additional home visit if prescribed by the patient's attending Physician.

- 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 normal 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. 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.

The following terms used within this provision are defined as shown below:
• Family Counseling - 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 - a relative by blood, marriage, or adoption who lives with or is the primary caregiver of the Terminally Ill person.

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

• Terminally Ill - a medical prognosis given by a Physician that a Covered Person’s life expectancy is six months or less.

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

Hospice Care Benefits also include the following:

• Bereavement Counseling for the Immediate Family or Family Caregiver of the Terminally Ill person for at least the six-month period following the Terminally Ill person’s death or 15 visits, whichever occurs first;

• Respite Care subject to the following:
  ▪ The annual benefit shall be at least 14 days; and
  ▪ We may limit any one Inpatient Stay for Respite Care to five consecutive days.

The following terms used within the two bulleted items above are defined as shown below:

• Bereavement Counseling - counseling provided to the Immediate Family or Family Caregiver of the Covered Person after the Terminally Ill person's death to help the Immediate Family or Family Caregiver cope with the death of the Terminally Ill person.

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

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).

• Hospital admission charges.

• Physician services for anesthesiologists, Emergency room Physicians, consulting Physicians, pathologists and radiologists. (Benefits for other Physician services are described under Physician Fees for Surgical and Medical Services.)

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).
• Pre-implantation Genetic Diagnosis (PGD) for diagnosis of genetic disorders only.

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 include, but are not limited to:
• Lab and radiology/X-ray.
• Mammography.

Benefits under this section include:
• The facility charge and the charge for supplies and equipment.
• Physician services for anesthesiologists, pathologists and radiologists. (Benefits for other Physician services 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.

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

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 or in a Physician's office.

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

15. Mental Health and Substance Abuse Services

Inpatient
Mental Health and Substance Abuse Services received on an inpatient basis in a Hospital or an Alternate Facility including Transitional Care and Residential Crisis Services.
The Mental Health/Substance Abuse Designee, who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

**Outpatient**

Mental Health and Substance Abuse Services received on an outpatient basis in a provider's office or at an Alternate Facility, including:

- Mental health, substance abuse and chemical dependency evaluations and assessment.
- Diagnosis including psychological and neuropsychological testing.
- Treatment planning.
- Referral services.
- Medication management.
- Short-term individual, family and group therapeutic services (including intensive outpatient therapy).
- Crisis intervention and Residential Crisis Services.
- Intermediate care.

Mental Health and Substance Abuse Services must be provided by or under the direction of the Mental Health/Substance Abuse Designee. Referrals to a Mental Health or Substance Abuse Services provider are at the discretion of the Mental Health/Substance Abuse Designee, who is responsible for coordinating all of your care. Contact the Mental Health/Substance Abuse Designee regarding Benefits for Outpatient/Intermediate and Inpatient Mental Health and Substance Abuse Services.

**16. Ostomy Supplies**

Benefits for ostomy supplies are limited to the following:

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

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

**17. 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.
18. 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.

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

19. 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 for Preventive Care provided in a Physician's office are described under Preventive Care Services.

Benefits under this section include lab, radiology/X-ray or other diagnostic services performed in the Physician's office.

20. 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 a normal vaginal delivery.
- 96 hours for the mother and newborn child following a 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 coverage for at least one home care visit as described above under Home Health Care. If the mother and newborn child remain in the Hospital for at least as long as the minimum inpatient confinement periods shown above, a single home visit will be provided if prescribed by the attending 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.

21. Preventive Care Services

Services for preventive medical care provided on an outpatient basis at a Physician’s office, an Alternate Facility or a Hospital. Examples of preventive medical care are:

**Physician office services:**
- Routine physical examinations.
- Well baby and well child care.
- Immunizations.
- Hearing screening.
- Insertion or removal of any contraceptive drug or device and associated medically necessary examination.

**Lab, X-ray or other preventive tests:**

(With the exception of cervical cancer screenings, coverage of the services listed below is required under Maryland law).

- Screening mammography.
  Benefits for screening mammography include:
  - A baseline mammogram for women 35 to 39 years of age;
  - A mammogram every two years, or more frequently if recommended by a Physician, for women 40 to 49 years of age.
  - An annual mammogram for women age 50 or older.
- Screening colonoscopy or sigmoidoscopy and other colorectal cancer screening tests in accordance with the latest screening guidelines issued by the American Cancer Society.
- Cervical cancer screening.
- 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, diagnosis, and treatment 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 are an individual with 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, who is a candidate for therapeutic intervention or for an extensive diagnostic evaluation for metabolic bone disease; 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 vertabral 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 federal Food and Drug Administration.

• A Human Papillomavirus Screening Test at the testing intervals for cervical cytology screenings 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 federal Food and Drug Administration.

22. Prosthetic Devices

External prosthetic devices that replace a limb or a body part, limited to:
• Artificial arms, legs, feet and hands.
• Artificial face, eyes, ears and noses.
• Speech aid prosthetics and tracheo-esophageal voice prosthetics.
• 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.

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

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

23. 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 all stages of reconstructive procedures include breast reconstruction following a mastectomy, and all stages of reconstructive breast surgery performed on 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, 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.

24. Rehabilitation Services - Outpatient Therapy and Chiropractic Treatment

Short-term outpatient rehabilitation services, limited to:

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

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 disorders.
25. 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, hysteroscopy.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. (Benefits for other Physician services 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.

26. 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 anesthesiologists, consulting Physicians, pathologists and radiologists. (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 but not limited to dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.

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.

27. 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, hysteroscopy.

Benefits under this section include:

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

28. Therapeutic Treatments - Outpatient
Therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including but not limited to 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.

29. 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.
30. 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.

31. Vision Examinations
Routine vision examinations, including refraction to detect vision impairment, received from a health care provider in the provider's office.

Please note that Benefits are not available for charges connected to the purchase or fitting of eyeglasses or contact lenses.

Benefits for eye examinations required for the diagnosis and treatment of a Sickness or Injury are provided under Physician's Office Services - Sickness and Injury.

Additional Benefits Required By Maryland Law

32. 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 or developmental 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.

33. Child Hearing Aid Coverage
Coverage is provided for hearing aids for a minor child if the hearing aids are prescribed, fitted, and dispensed by a licensed audiologist.

For the purpose of this benefit, "hearing aid" means a device that:
- Is of design and circuitry to optimize audibility and listening skills in the environment commonly experienced by children; and
- Is nondisposable.

34. Child Wellness Services
Coverage includes:
- 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;
- Services for age-appropriate screening tests for tuberculosis, anemia, lead toxicity, hearing and vision as determined 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.
35. Treatment of Cleft Lip or Palate or Both

Coverage for inpatient or outpatient orthodontic services, oral surgery, and otologic, audiological, and speech/language treatment for an Enrolled Dependent child in connection with cleft lip, cleft palate, or both. Services must be provided by or under the direction of a Physician.

36. Coverage for Clinical Trial Costs

Coverage for patient costs incurred during participation in clinical trials provided or arranged by a Physician for:

- Prevention, early detection and treatment studies on cancer.
- Treatment of other life-threatening conditions when ordered.
- Surgical musculoskeletal disorders of the spine, hip, and knees.

The treatment must be conducted in a Phase I, Phase II, Phase III, or Phase IV clinical trial approved by:

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

Coverage applies only if:

- The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise;
- There is no clearly superior noninvestigational treatment alternative;
- The available clinical or preclinical data provides a reasonable expectation that the treatment will be at least as effective as the noninvestigational alternative; and
- The Covered Person and his/her Physician conclude that participation in the clinical trial would be appropriate.

Coverage is provided only for the cost of Covered Health Services that is incurred as a result of the treatment being provided to the Covered Person for purpose of the clinical trial. Coverage is not provided for the cost of non-health care services that a patient may be required to receive as a result of the treatment being provided for purposes of a clinical trial, costs associated with managing the research associated with the clinical trial, or the cost of any investigational drug or device. However, coverage does include patient cost incurred for drugs and devices that have been approved for sale by the FDA whether or not the FDA has approved the drug or device for use in treating the patient's particular condition, to the extent the drugs or devices are not paid for by the manufacturer, distributor, or provider of that drug or device.

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

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

(1) 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

(2) 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 health services must be provided under the direction of a Physician or dentist. Coverage does not include expenses for the diagnosis or treatment of dental disease.

38. Habilitative Services
Except for Habilitative Services provided in early intervention and school services, Habilitative Services for children 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 (a) autism or autism spectrum disorder, and (b) cerebral palsy.

39. 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.

40. 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.
41. Medical Foods
Coverage 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.

42. Surgical Morbid Obesity Treatment
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 coverage, 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.
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 Chiropractic Treatment and 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 cancer or cleft lip/palate as described under Treatment of Cleft Lip or Cleft 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 Cleft 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. Devices used specifically as safety items or to affect performance in sports-related activities.

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

3. The following items are excluded, even if prescribed by a Physician:
   - Blood pressure cuff/monitor.
   - Enuresis alarm.
   - Home coagulation testing equipment.
   - Non-wearable external defibrillator.
• Trusses.
• Ultrasonic nebulizers.
• Ventricular assist devices.

4. Devices and computers to assist in communication and speech except for speech aid prosthetics and tracheo-esophageal voice prosthetics.

5. Oral appliances for snoring.

6. Repairs to prosthetic devices due to misuse, malicious damage or gross neglect.

7. 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.

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.

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 Coverage of Clinical Trial Costs 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:
   - Elastic 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/Substance Abuse
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. Treatment for Mental Illnesses that in the professional judgment of health care providers are deemed untreatable or not medically necessary.
3. Treatment provided in connection with or to comply with police detentions unless authorized by the Mental Health/Substance Abuse Designee.
I. 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. Except as described above under Medical Foods in Section 1: Covered Health Services, enteral feedings, even if the sole source of nutrition.
3. Infant formula and donor breast milk.
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) except as described above under Medical Foods in Section 1: Covered Health Services.

J. 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, dehumidifiers.
   - Batteries and battery chargers.
   - Breast pumps.
   - Car seats.
   - Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners.
   - Electric scooters.
   - 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.
- Speech generating devices.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

**K. 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, chmosurgery 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. **Breast reduction except as coverage is required by the Women's Health and Cancer Right's Act of 1998** for which Benefits are described under *Reconstructive Procedures* in Section 1: *Covered Health Services*.

5. **Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.**
6. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.

7. Wigs regardless of the reason for the hair loss except as described above under Hair Prosthesis in Section 1: Covered Health Services.

L. 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. 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 disorders. This exclusion does not apply to speech therapy services for which Benefits are provided as described under Treatment of Cleft Lip or Cleft Palate or Both or Habilitative Services in Section 1: Covered Health Services.

4. Psychosurgery.

5. Sex transformation operations.

6. 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.


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


10. Stand-alone multi-disciplinary smoking cessation programs.

M. 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. Foreign language and sign language interpreters.

N. Reproduction
1. The following infertility treatment-related services:
   - Cryo-preservation and other forms of preservation of reproductive materials.
   - 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.

O. 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.

P. 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.

Q. 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.

R. Types of Care
1. Multi-disciplinary pain management programs provided on an inpatient basis.

2. Custodial Care.

3. Domiciliary care.

4. Private duty nursing. This means 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.

5. Rest cures.

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

**S. Vision and Hearing**

1. Purchase cost and fitting charge for eye glasses and contact lenses.

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

3. Eye exercise therapy.

4. 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.

**T. 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*.

2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:
   - Required solely for purposes of career, school, sports or camp, travel, 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.

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.

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. 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 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 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 of a Subscriber for whom the court or the support enforcement agency has ordered the Subscriber to provide health care coverage is covered automatically from the date of the order. The Subscriber must pay any applicable premium necessary to provide coverage for such child. When the Subscriber does not include the child in the enrollment, we will allow the non-subscribing parent, the support enforcement agency, or the Department of Health and Mental Hygiene to apply for the enrollment on behalf of the child and include the child in the coverage under the Policy.
The 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 or subscription fee is required to provide coverage for any of the above, we will require notification and payment of the required Premium or fees will be furnished to us within 31 days after the birth, adoption, the court order, or appointment in order to have coverage continued beyond the 31 day period. Otherwise, coverage will terminate at the end of the 31 day period.

**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 and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period; and
- Coverage under the prior plan ended because of any of the following:
  - Loss of eligibility (including, but not limited to, legal separation, termination of employment, 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.

When an event takes place (for example, a birth or marriage), 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.

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. 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 or employer contributions ceased.
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 any of the following happen, we will provide written notice to the Subscriber that coverage has ended on the date we identify in the notice:

- **Fraud, Misrepresentation or False Information**
  
  Fraud or misrepresentation, or the Subscriber knowingly gave us false material information. Examples include false information relating to another person's eligibility or status as a Dependent.

- **Material Violation**
  
  There was a material violation of the terms of the Policy.

- **Threatening Behavior**
  
  You committed acts of physical or verbal abuse that pose a threat to our staff.

Coverage for a Disabled Dependent Child

Coverage for an unmarried Enrolled Dependent child who is disabled 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 handicap or disability 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 disabled 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 disability 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 disabled 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 disability and dependency within 31 days of our request as described above, coverage for that child will end.

Extension of Coverage

A temporary extension of coverage will be 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, treatment, or Hospital confinement ends; or (b) 12 months from the date coverage under the Policy would otherwise have terminated whichever occurs first.

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.

**Continuation of Coverage and Conversion**

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

Continuation coverage under COBRA (the federal Consolidated Omnibus Budget Reconciliation Act) is available only to Enrolling Groups that are subject to the terms of COBRA. You can contact your plan administrator to determine if your Enrolling Group is subject to the provisions of COBRA.

If you selected continuation coverage under a prior plan which was then replaced by coverage under 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 must be elected within 45 days of the date of the Subscriber's death and the Enrolled Dependent must make any required payment for coverage to the Enrolling Group.

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

- Eighteen (18) months after the date continuation coverage began;
For a Dependent child, the date coverage would otherwise terminate as described in Section 4;
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 under any other group health plan;
The date the Covered Person becomes covered under any non-group insurance policy or contract;
The date the Covered Person becomes entitled to benefits under Title XVIII of the Social Security Act; or
The date the Covered Person elects to 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 employer 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;
The date the Enrolling Group ceases to provide Benefits to its employees under a group contract;
The date the Covered Person becomes covered under any non-group insurance policy or contract;
The date the Covered Person becomes entitled to benefits under Title XVIII of the Social Security Act;
The date the Enrolled Dependent spouse remarries; 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;
- 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 under any other group health plan;
- The date the Covered Person becomes covered under any non-group insurance policy or contract;
- The date the Covered Person becomes entitled to benefits under Title XVIII of the Social Security Act;
- The date the Covered Person elects to terminate coverage.

Continuation of Coverage under State Law Due to Loss of Coverage due to Other Causes

A Covered Person who has been covered under the Policy for at least 3 months and whose coverage is terminated for any reason other than eligibility for Medicare, reaching a limiting age specified in the Policy, failure to pay a required Premium or contribution, fraud or misuse of I.D. card may elect to continue to be covered under the Policy for a period of 6 months. The Enrolling group shall notify the Covered Person whose coverage is being terminated on or before the date of such termination but not more than 61 days before. If the Enrolling Group fails to provide such notice, the Covered Person has the right to apply for a converted policy or for continuation of coverage within the time stated in the notice which shall be at least 31 days after the date of the notice, except that the late notice may not extend the period for making application beyond 90 days after the termination of coverage in the group Policy.

A Covered Person electing the option of continuing coverage under the Policy shall be required to remit monthly to the Enrolling Group the entire cost of his coverage. The entire cost shall be the sum of the amount which would have been contributed for his coverage by the Enrolling Group plus the amount of contribution which would have been required to be paid by the Covered Person if the Covered Person's coverage had not terminated.

If the Policy terminates before the end of the 6 months period of coverage or if the Enrolling Group refuses because of a labor dispute to remit Premiums due under the Policy, or if the Policy has been terminated, the Covered Person shall be required to remit Premiums for the balance of the period directly...
to us. In this event we may make a Premium surcharge not to exceed 20 percent of the entire cost of coverage under the Policy.

**Conversion**

A Covered Person who (1) has been continuously covered under the Policy (or any group plan which was replaced by the Policy) for a period of at least 3 months; and (2) whose coverage terminates for any reason other than failure to pay any required Premium or contribution, may make application to us for an individual policy of hospital and medical insurance coverage under a conversion contract without furnishing evidence of insurability.

Written application and payment of the initial Premium must be made within 31 days after the date of termination of coverage under the Policy or, if later than the date of termination, within 31 days of the date we notified the Covered Person of his or her right to convert coverage. A conversion contract shall be issued effective as of the date coverage under the Group Policy terminates and in accordance with the terms and conditions in effect at the time of application. The conversion contract may be substantially different from coverage provided under the Policy.

Each group contract subject to this section shall provide the same conversion rights and conditions to a covered dependent spouse of an employee, member, or subscriber that are provided to the covered employee, member, or subscriber, if the dependent spouse ceases to be a qualified family member because of divorce or the death of the employee, member, or subscriber.

Note: A conversion contract will not be issued to anyone who (a) is eligible for Medicare; or (b) was terminated for failure to pay Premium; or (c) is covered or eligible for coverage under another group policy which provides benefits substantially equal to the minimum benefits required by Maryland regulations governing conversion.
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 Annual 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).

Payment of Benefits

We will pay benefits within 30 days after we receive your request for payment that includes all required information. You may not assign your Benefits under the Policy to a non-Network provider without our consent. When an assignment is not obtained, we will send the reimbursement directly to you (the Subscriber) for you to reimburse them upon receipt of their bill. We may, however, in our discretion, pay a non-Network provider directly for services rendered to you.
When you assign your Benefits under the Policy to a non-Network provider with our consent, and the non-Network provider submits a claim for payment, you and the non-Network provider represent and warrant the following:

- The Covered Health Services were actually provided.
- The Covered Health Services were medically appropriate.

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**

**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 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**
An "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.

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, misrepresented, or omitted information.

If we render an adverse decision, notice of this adverse decision will be verbally communicated to you and your health care provider within 1 working day of the review determination. For the purpose of this Section, "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.

Written notification of the adverse decision will be sent to you and your health care provider within five working days following the verbal notification.
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 Covered Person's or a health care provider acting on behalf of the Covered Person's right to file an adverse decision complaint with the Insurance Commissioner within 30 working days of receipt of our grievance decision;
- The right to file an adverse decision complaint with the Insurance Commissioner without first filing an adverse decision grievance with us if the Covered Person or health care provider acting on behalf of the Covered Person 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 Education and Advocacy Unit of the Consumer Protection Division of the Office of the Attorney General.

Adverse Decision Grievances

If you have received an adverse decision, you, or your health care provider on your behalf, have the right to file an adverse decision grievance with us. An "adverse decision grievance" is a protest filed by the Covered Person, or health care provider on behalf of the Covered Person, with us through our internal adverse decision grievance process regarding an adverse decision concerning the Covered Person. The following conditions apply to adverse decision grievance filings:

- The adverse decision grievance must be filed by you, 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. A "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 concerning a Covered Person. 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, or your health care provider on your behalf, have the right to file an adverse decision complaint with the Insurance Commissioner, if you have not received our grievance decision on or before the 30th working day after the filing date.

- For retrospective denials (denials on Health Services that have already been rendered), we will render a grievance decision within 45 working days after the filing date.

- Unless written permission has been given, you, 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, 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 and/or your health care provider within five working days after the filing date. We will assist you 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.

• For retrospective denials, you, 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 or your health care provider. Written notification of our grievance decision will be sent to you 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.

• For prospective denials, you, 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 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 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, or your health care provider on your behalf, within 24 hours of receipt of the adverse decision grievance. If we need additional information in order to review the case, we will verbally inform you 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 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 and/or your health care provider the grievance decision in writing within one day of the verbal notification. The Notice of Grievance Decision will include the information specified for the Notice of Adverse Decision above.

Assistance From the Health Education and Advocacy Unit
The Health Education and Advocacy Unit of the Consumer Protection Division of the Office of the Attorney General is available to assist you with filing an adverse decision grievance under our internal adverse decision grievance process and assist you in mediating a resolution of our adverse decision.
NOTE: The Health Education and Advocacy Unit is not available to represent or accompany you during the proceedings. The Health Education and 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:

United HealthCare Insurance Company
4 Taft Court
Rockville, Maryland 20850
301-762-8205/ 1-800-544-2853

Adverse Decision Complaints to the Insurance Commissioner
An "adverse decision complaint" is a protest filed with the Insurance Commissioner involving an adverse decision or grievance decision concerning a Covered Person. Within 30 working days after receiving our Notice of Grievance Decision, or under the circumstances described above, you, 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
525 St. Paul Place
Baltimore, Maryland 21202-2272
1-800-492-6116 or 410-468-2000
Fax Number 410-468-2270

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

- For an emergency case, written notice of the Insurance Commissioner's final decision will be sent to the Covered Person and/or the health care provider within one working day after the Insurance Commissioner has given verbal notification of the final decision.
- For an adverse decision complaint involving a pending Health Service, written notice of the Insurance Commissioner's final decision will be sent to the Covered Person and/or the health care provider within 30 working 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 and/or the health care provider within 45 working 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
525 St. Paul Place
Baltimore, Maryland 21202
Telephone number: 1-800-492-6116
Fax number: (410) 468-2020

For assistance in resolving a billing or payment dispute with the Company or a provider, contact the Health Education and Advocacy Unit of the Consumer Protection Division of the Attorney General at:

Office of the Attorney General
Health Education and Advocacy Unit
200 St. Paul Place
Baltimore, Maryland 21202
Telephone number: (410) 528-1840
Fax number: (410) 576-6571
E-mail: consumer@oag.state.md.us

Coverage and Appeal Decisions

The following terms appearing below are defined as follows:

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

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

**Coverage Decision** - an initial determination by a carrier or a representative of the carrier that results in non-coverage of a health care service.
If a Coverage Decision results in non-coverage of a health care service including non-payment of all or any part of your claim, you, your representative, or your health care provider acting on your behalf, have a right to file an Appeal within one hundred eighty (180) calendar days of receipt of the Coverage Decision. The Appeal may be submitted verbally or in writing and should include any information you, your representative or a health care provider acting on your behalf believe will help us review your Appeal. You, your representative or a health care provider acting on your behalf may call Customer Service at the phone number listed on your identification card to verbally submit your Appeal. Send the written Appeal to: Customer Support Group, P.O. Box 933, Frederick, MD 21705. We will send you, your representative or a health care provider acting on your behalf a written response to your Appeal within thirty (30) calendar days of our receipt of your Appeal.

If you are dissatisfied with the outcome of the appeal, you, your representative or a health care provider acting on your behalf may file a complaint the Life and Health Complaint Unit, Maryland Insurance Administration, within sixty (60) working days after receipt of the Appeal Decision. You, your representative or a health care provider acting on your behalf may contact the Life and Health Complaint Unit, Maryland Insurance Administration, at 525 St. Paul Place, Baltimore, MD 21202, phone (410) 468-2000, toll free (800) 492-6116 or facsimile (410) 468-2260.

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

Health Education Advocacy Unit
Consumer Protection Division
Office of the Attorney general
100 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 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 behalf of a carrier, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, to result in:
  - Placing the member's life or health in serious jeopardy;
  - The inability of the member to regain maximum function;
  - Serious impairment to bodily function;
  - Serious dysfunction of any bodily organ or part; or
- The member remaining seriously mentally ill with symptoms that cause the member 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 member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the coverage decision.

**Voluntary External Review Program**

After you exhaust the appeal process, if we make a final determination to deny Benefits, you may choose to participate in our voluntary external review program. This program only applies if our decision is based on either of the following:

- Clinical reasons.
- The exclusion for Experimental or Investigational or Unproven Services.

The external review program is not available if our coverage determinations are based on Benefit exclusions or defined Benefit limits.

Contact us at the telephone number shown on your ID card for more information on the voluntary external review program.
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; specified disease or specified accident coverage; intensive care policies; 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.

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 and precertification of admissions.

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 and provides 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.

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 do not decide what care you need or will receive. You and your Physician make those decisions.
- 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.

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 Annual 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. 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 Annual Deductible. We do not pass these rebates on to you, nor are they applied to any Annual 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 Member under a personal injury protection policy. The Covered Person agrees to assign to us all rights of recovery against Third Parties, to the extent of the actual payments made us for the services and benefits that we provided.

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

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

Refund of Overpayments

If we pay Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to us if 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.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits for the Covered Person that are payable under the Policy. 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 Abuse Services on an outpatient or inpatient 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 pay 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 for a description of the in vitro fertilization benefit available to you.

**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.

**Chiropractic Treatment** - the therapeutic application of chiropractic 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.

**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:

- Provided for the purpose of preventing, diagnosing or treating a Sickness, Injury, Mental Illness, substance abuse, or their symptoms.
- Consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below.
- Not provided for the convenience of the Covered Person, Physician, facility or any other person.
- Described in this *Certificate of Coverage* under Section 1: Covered Health Services and in the Schedule of Benefits.
- Not otherwise excluded in this *Certificate of Coverage* under Section 2: Exclusions and Limitations.

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

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

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

**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 which do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the service is not changing.
- 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 an unmarried dependent child of the Subscriber or the Subscriber’s spouse. All references to the spouse of a Subscriber shall include a Domestic Partner. The term child includes any of the following:

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

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

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

- A Dependent includes any unmarried dependent child under 25 years of age.
- A Dependent includes an unmarried dependent child who is 25 years of age or older, but less than 26 years of age only if the following are true:
  - The child is not regularly employed on a full-time basis and
  - The child is primarily dependent upon the Subscriber for support and maintenance.
- A Dependent includes an unmarried child dependent of any age who is or becomes disabled and dependent upon the Subscriber.

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

A Dependent also includes a child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. We are responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order*.

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

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

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

- They must not be related by blood or a degree of closeness that would prohibit marriage in the law of the state in which they reside.
- They must not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
- They must share the same permanent residence and the common necessities of life.
- They must be at least 18 years of age.
- They must be mentally competent to consent to contract.
- They must be financially interdependent.

**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, 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 condition requiring immediate treatment of a sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that in the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in:

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

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

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

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

Experimental or Investigational Service(s) - medical, surgical, diagnostic, psychiatric, substance abuse 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 any institutional review board for the proposed use. (Devices which are FDA approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)

- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exceptions:

- Clinical trials for which Benefits are available as described under *Coverage of Clinical Trial Costs* in *Section 1: Covered Health Services*.

- Life-Threatening Sickness or Condition. If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, in our discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the *National Institutes of Health*.

**Home Health Agency** - a program or organization authorized by law to provide health care services in the home. The definition of a 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 Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

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

**Intermediate Care** - the provision of medically directed intensive or intermediate short-term treatment:

- To a Subscriber or Dependent;

- 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 four hours in a day.

**Intermittent Care** - skilled nursing care that is provided or needed either:
- Fewer than seven days each week; or
- 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.

**Maximum Policy Benefit** - for Benefit plans that have a Maximum Policy Benefit, this is the maximum amount that we will pay for Benefits during the entire period of time that you are enrolled under the Policy issued to the Enrolling Group. Refer to the Schedule of Benefits to determine whether or not your Benefit plan is subject to a Maximum Policy Benefit and for details about how the Maximum Policy Benefit applies.

**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 Abuse Designee** - the organization or individual, designated by us, that provides or arranges Mental Health Services and Substance Abuse 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 Food and Drug Administration.
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.

Pharmaceutical Product(s) - 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.

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, dietician or nutritionist, certified nurse-midwife, certified nurse practitioner, certified nurse anesthetist, social worker 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.

Pre-implantation Genetic Diagnosis (PGD) - a screening test typically performed in conjunction with in vitro fertilization (IVF) in which one or two cells are removed from an embryo to be screened for genetic abnormalities.

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.

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 a psychiatric crisis that would impair the individual's ability to function in the community;

• Designed to prevent a psychiatric inpatient admission, provide an alternative to psychiatric inpatient admission, or shorten the length of inpatient stay;

• Provided out of the Covered Person's residence on a short-term basis in a community-based residential setting; and

• Provided by entities that are licensed by the Department of Health and Mental Hygiene to provide residential crisis services.

Rider - any attached written description of additional Covered Health Services not described in this Certificate. Covered Health Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended in the Rider.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

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 Annual Deductible.

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

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

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

Subscriber - an Eligible Person who is properly enrolled under the Policy. The Subscriber is the person (who is not a Dependent) on whose behalf the Policy is issued to the Enrolling Group.

Substance Abuse 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/Substance Abuse Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

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

- Supervised living arrangement 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 ambulatory 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. (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, and that the service would be provided under standards equivalent to those defined by the National Institutes of Health.

- We may, in our discretion, consider an otherwise Unproven Service to be a Covered Health Service for a Covered Person with a Sickness or Injury that is not life-threatening. For that to occur, all of the following conditions must be met:
  - If the service is one that requires review by the U.S. Food and Drug Administration (FDA), it must be FDA-approved.
  - It must be performed by a Physician and in a facility with demonstrated experience and expertise.
  - The Covered Person must consent to the procedure acknowledging that we do not believe that sufficient clinical evidence has been published in peer-reviewed medical literature to conclude that the service is safe and/or effective.
  - At least two studies must be available in published peer-reviewed medical literature that would allow us to conclude that the service is promising but unproven.

The decision about whether such a service can be deemed a Covered Health Service is solely at our discretion. Other apparently similar promising but unproven services may not qualify.

**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.
Dependent, Domestic Partner, Domestic Partnership Definitions Amendment

UnitedHealthcare Insurance Company

As described in this Amendment, the Policy is amended to provide revised definitions of Dependent, Domestic Partner, and Domestic Partnership.

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 and in this Amendment below.

1. The definition from the Certificate for Dependent in Section 9: Defined Terms is deleted in its entirety and replaced with the following:

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

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A grandchild.
- A child, for whom legal custody or testamentary or court appointed guardianship other than temporary guardianship of less than 12 months duration has been awarded to the Subscriber or the Subscriber’s spouse.

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

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

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

The Subscriber must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy these conditions.
A Dependent also includes a child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. We are responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order*.

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

- 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.

2. The definitions from the *Certificate for Domestic Partner and Domestic Partnership in Section 9: Defined Terms* are deleted in their entirety and replaced with the following:

**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.

UNITEDHEALTHCARE INSURANCE COMPANY

Jeffrey Alter, President
Amino Acid Based Elemental Formula and Conversion Amendment

UnitedHealthcare Insurance Company

As described in this Amendment, the Policy is modified to provide coverage for Amino Acid Based Elemental Formula and compliance with the new Maryland conversion requirements.

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

Amino Acid Based Elemental Formula

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

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

b. Severe Food Protein induced Enterocolitis Syndrome;

c. Eosinophilic disorders (as evidenced by results of a biopsy); and

d. Impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.

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<tr>
<th>Covered Health Service</th>
<th>Benefit (The Amount We Pay, based on Eligible Expenses)</th>
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<th>Must You Meet Annual Deductible?</th>
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2. Items 2. and 3. of the exclusion for Nutrition in the Certificate under Section 2: Exclusions and Limitations, are replaced with the following:

2. Except as described above under Amino Acid Based Elemental Formula and Medical Foods in Section 1: Covered Health Services; enteral feedings, even if the sole source of nutrition.

3. Infant formula and donor breast milk, except as described above under Amino Acid Based Elemental Formula in Section 1: Covered Health Services.

3. The provision in the Certificate under Section 4: When Coverage Ends, Conversion is replaced with the following:
Conversion

A Covered Person may make application to us for an individual policy of hospital and medical insurance coverage under a conversion contract without furnishing evidence of insurability if the Covered Person (1) has been continuously covered under the group Policy (or any group plan which was replaced by the group Policy) for a period of at least 3 months; and (2) whose coverage terminates for any reason other than the following:

- Covered Person is enrolled in a health maintenance organization, or is covered or eligible for coverage under another group policy that provides benefits substantially equal to the minimum benefits required by Maryland regulations.
- Covered Person is eligible for Medicare.
- Covered Person’s group Policy coverage is terminated for any of the following reasons:
  1. Covered Person performed an act or practice that constitutes fraud in connection with the Policy.
  2. Covered Person made an intentional misrepresentation of a material fact under the Policy terms.
  3. The terminated coverage under the group Policy was replaced by similar coverage within thirty-one (31) days after the date of termination of the group Policy.
  4. Covered Person’s failed to pay any required premium.

A Covered Person, meeting the requirements to convert coverage, will be notified of this right on or before the termination date of the group Policy coverage, but not more than sixty-one (61) days before the termination date of the group Policy coverage. If the Covered Person does not receive notification within the above timeframe, he or she will be allowed to, within the time stated in a late notice, apply for conversion coverage at least thirty-one (31) days after the date of late notification. The late notice will not extend the conversion application period beyond ninety (90) days after the termination date of the group Policy coverage.

Written application and payment of the initial Premium must be made within forty-five (45) days after the date of termination of coverage under the Policy or, if notice is received after the date of termination, within thirty-one (31) days of the date we notified the Covered Person of his or her right to convert coverage. A conversion contract shall be issued effective as of the date coverage under the Group Policy terminates and in accordance with the terms and conditions in effect at the time of application. The conversion contract may be substantially different from coverage provided under the Policy.

Each group contract subject to this section shall provide the same conversion rights and conditions to a covered dependent spouse of an employee, member, or subscriber that are provided to the covered employee, member, or subscriber, if the dependent spouse ceases to be a qualified family member because of divorce or the death of the employee, member, or subscriber.

UNITEDHEALTHCARE INSURANCE COMPANY

Jeffrey Alter, President
Patient Protection and Affordable Care Act (PPACA) Amendment

UnitedHealthcare Insurance Company

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

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

Children's Coverage to Age 26

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

Eligibility

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

Termination

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

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

Definition of Child

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

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

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

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

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

**Definitions**

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

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

- A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition, and
- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

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

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

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

**Non-Participating Provider** – means a health care practitioner or health care facility that has not contracted directly with UnitedHealthcare Insurance Company or an entity contracting on behalf of UnitedHealthcare Insurance Company to provide health care services to UnitedHealthcare Insurance Company’s enrollees.
Participating Provider – means a health care practitioner or health care facility that has contracted directly with UnitedHealthcare Insurance Company or an entity contracting on behalf of UnitedHealthcare Insurance Company to provide health care services to UnitedHealthcare Insurance Company's enrollees.

Lifetime Dollar Limits (Maximum Policy Benefit)
Any lifetime dollar limit on any Essential Health Benefits in the group contract is deleted.

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

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

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

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

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

- Evidenced-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force, except that the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention of breast cancer shall be considered the most current other than those issued in or around November 2009;
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- With respect to women, such additional preventive care and screenings, not described in the first bullet point above, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.
For services received from Non-Participating Providers, the preventive service benefits described above shall be covered at eighty percent (80%) of the amount covered for services received from Participating Providers.

UnitedHealthcare Insurance Company shall update new recommendations to the preventive benefits listed above at the schedule established by the Secretary of Health and Human Services.

**Prohibition on Pre-Existing Conditions for Children**

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

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

**Emergency Services**

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

- Without the need for any prior authorization determination, even if the Emergency Services are provided by a Non-Participating Provider;
- Without regard to whether the health care provider furnishing the Emergency Services is a Participating Provider with respect to the services; and
- If the Emergency Services are provided by a Non-Participating Provider, without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to Emergency Services received from Participating Providers.

**Cost-Sharing Requirements for Emergency Services**

If any copayment amount or coinsurance percentage described in the group contract for Emergency Services is different for a service received from a Participating Provider than a Non-Participating Provider, the copayment amount and coinsurance percentage for Emergency Services provided by a Non-Participating Provider is amended to be identical to the copayment amount and coinsurance percentage listed in the group contract for Emergency Services provided by a Participating Provider.

UnitedHealthcare Insurance Company shall pay the greater of the following amounts for Emergency Services received from Non-Participating Providers:

- The amount set forth in the group contract to which this amendment rider is attached.
- The amount negotiated with Participating Providers for the Emergency Services provided, excluding any copayment or coinsurance that would be imposed if the service had been received from a Participating Provider. If there is more than one amount negotiated with Participating Providers for the Emergency Service provided, the amount paid shall be the median of these negotiated amounts, excluding any copayment or coinsurance that would be imposed if the service had been received from a Participating Provider.
• The amount for the Emergency Service calculated using the same method UnitedHealthcare Insurance Company generally used to determine payments for services provided by a Non-Participating Provider (such as usual, customary and reasonable amount), excluding any copayment or coinsurance that would be imposed if the service had been received from a Participating Provider.

• The amount that would be paid under Medicare (part A or part B of title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq.) for the Emergency Service, excluding any copayment or coinsurance that would be imposed if the service had been received from a Participating Provider.

Any other provision of the group contract that describes cost-sharing for services received from Non-Participating Providers, other than copayment amounts or coinsurance responsibilities, continue to apply to Emergency Services received from Non-Participating Providers. Examples of these cost-sharing requirements include deductibles and out-of-pocket limits. Any out-of-pocket limit described in the group contract that generally applies to services received from Non-Participating Providers is applicable to Emergency Services received from Non-Participating Providers.

Effective Date of this Amendment: January 1, 2013

UNITEDHEALTHCARE INSURANCE COMPANY

Jeffrey Alter, President
Questions, Complaints and Appeals Amendment

UnitedHealthcare Insurance Company

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

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

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 utilization review determination that a proposed or delivered Covered Health Service which would otherwise be covered under the Policy is not or was not Medically Necessary, appropriate or efficient, and may result in non-coverage of the health care service; or our denial of a request by a Covered Person for an alternative standard or a waiver of a standard for a bona wellness program, if applicable under the Policy, as required under Maryland insurance law.

- "Adverse decision complaint" is a protest filed with the Insurance Commissioner involving an adverse decision or grievance decision concerning a Covered Person.

- "Adverse decision grievance" means a protest by you, your representative, or your health care provider on your behalf with us through our internal grievance process regarding an adverse decision.
"Compelling reason" means to show that a potential delay in receipt of a health care service until after the Covered Person or health care provider exhausts the internal grievance process and obtains a final decision under the grievance process could result in loss of life, serious impairment to a bodily function, serious dysfunction of a bodily organ, or the Covered Person remaining seriously mentally ill with symptoms that cause the Covered Person to be in danger to self or others.

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

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

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

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

"Your representative" means an individual who has been authorized by you to file a grievance or 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 a your behalf, may file a complaint with the Commissioner without first filing a 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 a compelling reason 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 after the adverse decision has been made.

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

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

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

Adverse Decision Grievances

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

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

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

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

- If we need additional information in order to review the case, we will notify you, your representative and/or your health care provider within five working days after the filing date. We will assist you, your representative, or the health care provider in gathering the necessary medical records without further delay. If no additional information is available or is not submitted to us, we will render a decision based on the available information.

- Except as described under the first two bullets in the Complaints provision above, for retrospective denials, you, your representative, or your health care provider on your behalf, must file an adverse decision grievance with us before filing an adverse decision complaint with the Insurance Commissioner, as described below.

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

- In addition to the first two bullets of the Complaints provision above, for prospective denials, you, your representative, or your health care provider on your behalf, may file an adverse decision complaint with the Insurance Commissioner (see below) without first filing an adverse decision grievance with us, if you, your representative, or your health care provider can demonstrate that the adverse decision concerns a compelling reason for which a delay would result in loss of life, serious impairment to a bodily function, serious dysfunction of a bodily organ or the Covered Person remaining seriously mentally ill with symptoms that cause the Covered Person to be in danger to self or others.

**Expedited Review in Emergency Cases**

In emergency cases, you 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.

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

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

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

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

UnitedHealthcare Insurance Company
4 Taft Court
Rockville, Maryland 20850
Adverse Decision Complaints to the Insurance Commissioner

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

Maryland Insurance Administration
Appeals and Grievance Unit
200 St. Paul Place, Suite 2700
Baltimore, Maryland 21202
1-800-492-6116 or 410-468-2000
Fax Number 410-468-2270

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

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

Health Education and Advocacy Unit
200 St. Paul Place, 16th Floor
Baltimore, Maryland 21202
Telephone number: (410) 528-1840
Fax number: (410) 576-6571
E-mail: consumer@oag.state.md.us

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

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

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

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

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

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

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

Office of the Attorney General
Health Education and Advocacy Unit
200 St. Paul Place, 16th Floor
Baltimore, Maryland 21202
Telephone number: (410) 528-1840
Fax number: (410) 576-6571
E-mail: consumer@oag.state.md.us

Coverage and Appeal Decisions

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

- "Appeal" means a protest filed by a Covered Person, a Covered Person's representative or a health care provider with us under our internal appeal process regarding a coverage decision concerning a Covered Person.

- "Appeal decision" means a final determination made by us that arises from an appeal filed with us under our appeal process regarding a coverage decision concerning a Covered Person.

- "Coverage decision" means:
  - an initial determination by us or our representative that results in non-coverage of a health care service;
  - a determination by us that an individual is not eligible for coverage under the Policy;
  - any determination by us that results in the rescission of an individual's coverage under the Policy.

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

A coverage decision does not include:
• an adverse decision as described above; or
• a pharmacy inquiry.

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

• "Pharmacy inquiry" means an inquiry submitted by a pharmacist or pharmacy on behalf of a Covered Person to us or a pharmacy benefits manager at the point of sale about the scope of pharmacy coverage, pharmacy benefit design, or formulary, if available, under the Policy.

• "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.

**Assistance From the Health Education and Advocacy Unit**

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

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

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

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

"Urgent medical condition" means a condition that satisfies either of the following:

- A medical condition, including a physical condition, a mental condition, or a dental condition, where the absence of medical attention within 72 hours could reasonably be expected by an individual, acting on our behalf, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, to result in:
  - Placing the Covered Person's life or health in serious jeopardy;
  - The inability of the Covered Person to regain maximum function;
  - Serious impairment to bodily function;
  - Serious dysfunction of any bodily organ or part; or
  - The Covered Person remaining seriously mentally ill with symptoms that cause the Covered Person to be a danger to self or others; or
- A medical condition, including a physical condition, a mental health condition, or a dental condition, where the absence of medical attention within 72 hours in the opinion of a health care provider with knowledge of the Covered Person's medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the coverage decision.

UNITEDHEALTHCARE INSURANCE COMPANY

Jeffrey Alter, President
Dependent Amendment

UnitedHealthcare Insurance Company

As described in this Amendment, the Policy is modified to provide a revised definition for Dependent.

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

Because this Amendment is part of a legal document (the group Policy), we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the Certificate of Coverage (Certificate) in Section 9: Defined Terms and in this Amendment below.

1. The definition of Dependent in the Certificate under Section 9: Defined Terms is replaced with the following:

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

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A grandchild who is unmarried and a dependent of the Subscriber or the Subscriber's spouse as that term is used in 26 U.S.C. §§ 104, 105, and 106, and any regulations adopted under those sections.
- A child for whom legal custody or testamentary or court appointed guardianship other than temporary guardianship of less than 12 months duration has been awarded to the Subscriber or the Subscriber's spouse.

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.

UNITEDHEALTHCARE INSURANCE COMPANY

Jeffrey Alter, President
Infertility Services Amendment

UnitedHealthcare Insurance Company

As described in this Amendment, the Policy is modified to provide a revised *Infertility Services* Benefit provision and to remove specific definitions, as described below.

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

Because this Amendment is part of a legal document (the group Policy), we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage* (*Certificate*) in Section 9: *Defined Terms* and in this Amendment below.

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

**Infertility Services**

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

Benefits are provided for the following infertility services:

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

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

2. The definition of Pre-implantation Genetic Diagnosis (PGD) in the *Certificate* under *Section 9: Defined Terms* is deleted.

3. The definition of Assisted Reproductive Technology (ART) in the *Certificate* under *Section 9: Defined Terms* is deleted.
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 or is prescribed to prevent conception.

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 for the supply that exceeds the limit.

You may determine whether a Prescription Drug Product has been assigned a maximum quantity level for dispensing through the Internet at www.myuhc.com or by calling Customer Care at the telephone number on your ID card.

Notification Requirements
Before certain Prescription Drug Products are dispensed to you, either your Physician, your pharmacist or you are required to notify us or our designee. The reason for notifying us is to determine whether the Prescription Drug Product, in accordance with our approved guidelines, is each of the following:

- It meets the definition of a Covered Health Service.
- It is not an Experimental or Investigational or Unproven Service.

Network Pharmacy Notification
When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for notifying us.
Non-Network Pharmacy Notification

When Prescription Drug Products are dispensed at a non-Network Pharmacy, you or your Physician are responsible for notifying us as required.

If we are not notified before the Prescription Drug Product is dispensed, you may pay more for that Prescription Order or Refill. The Prescription Drug Products requiring notification are subject to our periodic review and modification. You may determine whether a particular Prescription Drug Product requires notification through the Internet at www.myuhc.com or by calling Customer Care at the telephone number on your ID card.

If we are not notified before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You may be required to pay for the Prescription Drug Product at the pharmacy. Our contracted pharmacy reimbursement rates (our Prescription Drug Cost) will not be available to you at a non-Network Pharmacy. You may seek reimbursement from us as described in the Certificate of Coverage in Section 5: How to File a Claim.

When you submit a claim on this basis, you may pay more because you did not notify us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Cost (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 of Coverage are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

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 are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table.

The amount you pay for any of the following under this Rider will not be included in calculating any Out-of-Pocket Maximum stated in your Certificate of Coverage:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Cost) will not be available to you.
Payment Information

<table>
<thead>
<tr>
<th>Payment Term And Description</th>
<th>Amounts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copayment and Coinsurance</td>
<td></td>
</tr>
</tbody>
</table>

**Copayment**

Copayment for a Prescription Drug Product at a Network or non-Network Pharmacy is a specific dollar amount.

**Coinsurance**

Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Cost.

Coinsurance for a Prescription Drug Product at a non-Network Pharmacy is a percentage of the Predominant Reimbursement Rate.

**Copayment and Coinsurance**

Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List Management Committee has assigned a Prescription Drug Product.

NOTE: The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. 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.

For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of:

- The applicable Copayment and/or Coinsurance or
- The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product.

For Prescription Drug Products from a mail order Pharmacy, you are responsible for paying the lower of:

- The applicable Copayment and/or Coinsurance or
- The Prescription Drug Cost for that Prescription Drug Product.

See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts.
### 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>Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List 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.</td>
</tr>
<tr>
<td>The following supply limits apply:</td>
<td></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>
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</tr>
<tr>
<td>• When a Specialty 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 Specialty Prescription Drug Product; and</td>
<td></td>
</tr>
<tr>
<td>▪ Thereafter, up to a consecutive 90 day supply of a Specialty Prescription Drug Product subject to a Copayment up to 2 times the Copayment for a 31-day supply.</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>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></td>
</tr>
<tr>
<td><strong>Prescription Drugs from a Retail or Mail Order Network Pharmacy</strong></td>
<td></td>
</tr>
<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 Management Committee has assigned the Prescription Drug Product. All</td>
</tr>
<tr>
<td>• As written by the provider, up to a</td>
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*Network Retail or Mail Order Pharmacy*

For a Tier-1 Specialty Prescription Drug Product: 100% of the Prescription Drug Cost after you pay a Copayment of $10.00 per Prescription Order or Refill.

For a Tier-2 Specialty Prescription Drug Product: 100% of the Prescription Drug Cost after you pay a Copayment of $30.00 per Prescription Order or Refill.

For a Tier-3 Specialty Prescription Drug Product: 100% of the Prescription Drug Cost after you pay a Copayment of $50.00 per Prescription Order or Refill.

*Non-Network Retail or Mail Order Pharmacy*

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.

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.

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.
### Description and Supply Limits

- 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 classified as a Maintenance Medication according to Maryland law and as written by the provider:
    - Up to a consecutive 31-day supply for a new prescription or a change in prescription of a Prescription Drug Product; and
    - Thereafter, up to a consecutive 90 day supply of a Prescription Drug Product subject to a Copayment up to 2 times the Copayment for a 31-day supply.

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.

### Benefit (The Amount We Pay)

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 Prescription Drug Cost 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 Cost 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 Cost after you pay a Copayment of $50.00 per Prescription Order or Refill.

### 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

Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1, Tier-2 or Tier-3. Please access www.myuhc.com through the Internet or call Customer Care at the telephone number on your ID card to determine tier status.

For a Tier-1 Prescription Drug Product: 100% of the
<table>
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<td>Predominant Reimbursement Rate after you pay a Copayment of $10.00 per Prescription Order or Refill.</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>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.</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>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>
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<td>▪ Thereafter, up to a consecutive 90 day supply of a Prescription Drug Product subject to a Copayment up to 2 times the Copayment for a 31-day supply.</td>
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<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>
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</tr>
</tbody>
</table>
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 the Certificate of Coverage in Section 9: Defined Terms and 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 of Coverage in Section 9: Defined Terms.

NOTE: The Coordination of Benefits provision in the Certificate of Coverage 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 of Coverage.

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 supply limits or notification requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, available rebates and assessments on the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are more cost effective for specific indications as compared to others; therefore, a Prescription Drug Product may be listed on multiple tiers according to the indication for which the Prescription Drug Product was prescribed.

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 of Coverage 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 Cost, less the required Copayment and/or Coinsurance, and any deductible that applies.

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.

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 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 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 Prescription Drug Rider. We are not required to pass on to you, and do not pass on to you, such amounts.
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 or is prescribed to prevent conception.

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

If you require Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Specialty Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Specialty Prescription Drug Product from a Designated Pharmacy, 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 Food and Drug Administration 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 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, you 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.
Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on retail non-Network Pharmacy supply limits.

**Prescription Drug Products from a Mail Order Pharmacy**

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Pharmacy.

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 of Coverage apply also to this Rider, except that any preexisting condition exclusion in the Certificate of Coverage is not applicable to this Rider. In addition, the following exclusions apply:

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.


3. Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.

4. 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 coverage for Prescription Drug Products that have been approved for sale by the federal Food and Drug Administration whether or not the FDA has approved the Prescription Drug Product for use in treatment of 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.

5. Prescription Drug Products furnished by the local, state or federal government.

6. 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.

7. Any product dispensed for the purpose of appetite suppression or weight loss.

8. A Pharmaceutical Product for which Benefits are provided in your Certificate of Coverage. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception as defined in Section 3 under Prescription Drug Product.

9. Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.

10. General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.

11. Unit dose packaging of Prescription Drug Products.

12. Medications used for cosmetic purposes.

13. 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.

14. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.

15. Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a Prescription Order or Refill. 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.)
16. 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. 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 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 the Subscriber's disease or condition; or
  - Has caused or is likely to cause an adverse reaction or other harm to the Subscriber.

17. New Prescription Drug Products and/or new dosage forms until the date they are assigned to a tier by our Prescription Drug List Management Committee. However, we will provide immediate coverage for a New Prescription Drug Product if, in the 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 the Subscriber's disease or condition; or
  - Has caused or is likely to cause an adverse reaction or other harm to the Subscriber.

18. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).

19. 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).

20. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. 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 PrescriptionDrug List:
  - Has been ineffective in treating the Subscriber's disease or condition; or
  - Has caused or is likely to cause an adverse reaction or other harm to the Subscriber.

21. 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. 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 the Subscriber's disease or condition; or
  - Has caused or is likely to cause an adverse reaction or other harm to the Subscriber.
Section 3: Defined Terms

**Authorized Prescriber** - has the meaning stated in Section 12-101 of the Health Occupations 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, 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, 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.

**Maintenance Medication** - A Prescription Drug Product anticipated to be used for six months or more to treat a chronic condition. Contact us to obtain a copy of the list of Maintenance Medications.

**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.

- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.

- 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 and ending on the earlier of the following dates:

- The date it is assigned to a tier by our Prescription Drug List Management Committee.

- December 31st of the following calendar year.

**Nicotine Replacement Therapy** - a Prescription Drug Product that:

- 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.

**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 Cost that applies for that particular Prescription Drug Product at most Network Pharmacies.

Prescription Drug Cost - the rate we have agreed to pay our Network Pharmacies, including a 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. 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 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 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: Schedule of Benefits in your Certificate of Coverage for more information.
- Contraceptive drugs or devices that are approved by the United States Food and Drug Administration 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-injectable 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 can be expected to produce essentially the same therapeutic outcome and toxicity.
**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)

IMPORTANT NOTICE: If you have a dependent child whose coverage ended or who was denied coverage (or was not eligible for coverage) because dependent coverage of children was not available up to age 26, you may have the right to enroll that dependent under a special dependent child enrollment period. This right applies as of the first day of the first plan year beginning on or after September 23, 2010 and your employer (or enrolling group) must provide you with at least a 30 day enrollment period. If you are adding a dependent child during this special enrollment period and have a choice of coverage options under the plan, you will be allowed to change options. This child special open enrollment may coincide with your annual open enrollment, if you have one. Please contact your employer or group plan administrator for more information.

IMPORTANT NOTICE: If coverage or benefits for you or a dependent ended due to reaching a lifetime limit, be advised that a lifetime limit on the dollar value of benefits no longer applies. If you are covered under the plan, you are once again eligible for benefits. Additionally, if you are not enrolled in the plan, but are still eligible for coverage, then you will have a 30 day opportunity to request enrollment. This 30 day enrollment opportunity will begin no later than the first day of the first plan year beginning on or after September 23, 2010. This 30 day enrollment period may coincide with your annual open enrollment, if you have one. Please contact your employer or group health plan administrator for more information.
Changes in Federal Law that Impact Benefits

There are changes in Federal law which may impact coverage and Benefits stated in the Certificate of Coverage (Certificate) 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; maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

- On or before the first day of the first plan year beginning on or after September 23, 2010, the enrolling group will provide a 30 day enrollment period for those individuals who are still eligible under the plan's eligibility terms but whose coverage ended by reason of reaching a lifetime limit on the dollar value of all benefits.

- Essential benefits for plan years beginning prior to January 1, 2014 can only be subject to restricted annual limits. Restricted annual limits for each person covered under the plan may be no less than the following:
  
  - For plan or policy years beginning on or after September 23, 2010 but before September 23, 2011, $750,000.
  - For plan or policy years beginning on or after September 23, 2011 but before September 23, 2012, $1,250,000.
  - For plan or policy years beginning on or after September 23, 2012 but before January 1, 2014, $2,000,000.

- Any pre-existing condition exclusions (including denial of benefits or coverage) will not apply to covered persons under the age of 19.

- Coverage for enrolled dependent children is no longer conditioned upon full-time student status or other dependency requirements and will remain in place until the child's 26th birthday. If you have a grandfathered plan, the enrolling group is not required to extend coverage to age 26 if the child is eligible to enroll in an eligible employer-sponsored health plan (as defined by law). Under the PPACA a plan generally is "grandfathered" if it was in effect on March 23, 2010 and there are no substantial changes in the benefit design as described in the Interim Final Rule on Grandfathered Health Plans.

  On or before the first day of the first plan year beginning on or after September 23, 2010, the enrolling group will provide a 30 day dependent child special open enrollment period for dependent children who are not currently enrolled under the policy and who have not yet reached age 26. During this dependent child special open enrollment period, subscribers who are adding a dependent child and who have a choice of coverage options will be allowed to change options.

- If your plan includes coverage for enrolled dependent children beyond the age of 26, which is conditioned upon full-time student status, the following applies:
Coverage for enrolled dependent children who are required to maintain full-time student status in order to continue eligibility under the policy is subject to the statute known as Michelle's Law. This law amends ERISA, the Public Health Service Act, and the Internal Revenue Code and requires group health plans, which provide coverage for dependent children who are post-secondary school students, to continue such coverage if the student loses the required student status because he or she must take a medically necessary leave of absence from studies due to a serious illness or injury.

- If you do not have a grandfathered plan, 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.

Some Important Information about Appeal and External Review Rights under PPACA

If you are enrolled in a non-grandfathered plan with an effective date or plan year anniversary on or after September 23, 2010, the Patient Protection and Affordable Care Act of 2010 (PPACA), as amended, sets forth new and additional internal appeal and external review rights beyond those that some plans may have previously offered. Also, certain grandfathered plans are complying with the additional internal appeal and external review rights provisions on a voluntary basis. Please refer to your benefit plan documents, including amendments and notices, or speak with your employer or UnitedHealthcare for...
more information on the appeal rights available to you. (Also, please refer to the Claims and Appeal Notice section of this document.)

**What if I receive a denial, and need help understanding it?** Please call UnitedHealthcare at the number listed on the back of your health plan ID card.

**What if I don't agree with the denial?** You have a right to appeal any decision to not pay for an item or service.

**How do I file an appeal?** The initial denial letter or Explanation of Benefits that you receive from UnitedHealthcare will give you the information and the timeframe to file an appeal.

**What if my situation is urgent?** If your situation is urgent, your review will be conducted as quickly as possible. If you believe your situation is urgent, you may request an expedited review, and, if applicable, file an external review at the same time. For help call UnitedHealthcare at the number listed on the back of your health plan ID card.

Generally, an urgent situation is when your health may be in serious jeopardy. Or when, in the opinion of your doctor, you may be experiencing severe pain that cannot be adequately controlled while you wait for a decision on your appeal.

**Who may file an appeal?** Any member or someone that member names to act as an authorized representative may file an appeal. For help call UnitedHealthcare at the number listed on the back of your health plan ID card.

**Can I provide additional information about my claim?** Yes, you may give us additional information supporting your claim. Send the information to the address provided in the initial denial letter or Explanation of Benefits.

**Can I request copies of information relating to my claim?** Yes. There is no cost to you for these copies. Send your request to the address provided in the initial denial letter or Explanation of Benefits.

**What happens if I don't agree with the outcome of my appeal?** If you appeal, we will review our decision. We will also send you our written decision within the time allowed. If you do not agree with the decision, you may be able to request an external review of your claim by an independent third party. They will review the denial and issue a final decision.

**If I need additional help, what should I do?** For questions on your appeal rights, you may call UnitedHealthcare at the number listed on the back of your health plan ID card. You may also contact the support groups listed below.

**Are verbal translation services available to me during an appeal?** Yes. Contact UnitedHealthcare at the number listed on the back of your health plan ID card. Ask for verbal translation services for your questions.

**Is there other help available to me?** For questions about appeal rights, an unfavorable benefit decision, or for help, you may also contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272). Your state consumer assistance program may also be able to help you.

For information on appeals and other PPACA regulations, visit www.healthcare.gov.

**Americans with Disabilities Act**

Effective for Policies that are new or renewing on or after October 3, 2009, changes in interpretation of the Americans with Disabilities Act result in the following additional Benefits:

- Benefits are provided for hearing aids required for the correction of a hearing impairment and for charges for associated fitting and testing.
Benefits for hearing aids are subject to payment requirements (Coinsurance, Annual Deductible and Out-of-Pocket Maximums) and annual limits that mirror those applicable to Durable Medical Equipment and Prosthetic Devices as shown in the Schedule of Benefits, however Benefits for hearing aids will never exceed $5,000 per year.

- Benefits for bone anchored hearing aids are a Covered Health Service for which Benefits are provided under the applicable medical/surgical Benefit categories in the Certificate only for Covered Persons who have either of the following:
  - Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
  - Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

Benefits for bone anchor hearing aids are limited to one per Covered Person during the entire period of time the Covered Person is enrolled under the Policy, and include repairs and/or replacement only if the bone anchor hearing aid malfunctions.

**Mental Health/Substance Use Disorder Parity**

Effective for Policies that are new or renewing on or after July 1, 2010, Benefits are subject to final regulations supporting the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Benefits for mental health conditions and substance use disorder conditions that are Covered Health Services under the Policy must be treated in the same manner and provided at the same level as Covered Health Services for the treatment of other Sickness or Injury. Benefits for Mental Health Services and Substance Use Disorder Services are not subject to any annual maximum benefit limit (including any day, visit or dollar limit).

MHPAEA requires that the financial requirements for coinsurance and copayments for mental health and substance use disorder conditions must be no more restrictive than those coinsurance and copayment requirements for substantially all medical/surgical benefits. MHPAEA requires specific testing to be applied to classifications of benefits to determine the impact of these financial requirements on mental health and substance use disorder benefits. Based upon the results of that testing, it is possible that coinsurance or copayments that apply to mental health conditions and substance use disorder conditions in your benefit plan may be reduced.

Changes that result from this requirement affect both prior authorization requirements and excluded services listed in your Certificate as described below.

Exclusions listed in your Certificate for mental health conditions, neurobiological disorders (autism spectrum disorders) and substance use disorders that were specific to these conditions, but that were not applicable to other Sickness or medical conditions, no longer apply.

Prior authorization requirements no longer apply to mental health conditions, neurobiological disorders (autism spectrum disorders) and substance use disorders. Instead, these services will be subject to the pre-service notification requirements that apply to other Covered Health Services described in the Schedule of Benefits attached to your Certificate.

When Benefits are provided for any of the following services, you must provide pre-service notification as described below. If you fail to notify us as required, Benefits will be reduced in the same manner and at the same level as Covered Health Services for the treatment of other Sickness or Injury. You are not required to provide pre-service notification when you seek these services from Network providers. Network providers are responsible for notifying us before they provide these services to you.

- Mental Health Services - inpatient services (including partial hospitalization/day treatment and residential treatment); intensive outpatient program treatment; outpatient electro-convulsive
treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; outpatient treatment provided in your home.

- Neurobiological Disorders - Autism Spectrum Disorder services - inpatient services (including partial hospitalization/day treatment and residential treatment); intensive outpatient program treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; outpatient treatment provided in your home. If Benefits are provided for Applied Behavioral Analysis (ABA), pre-service notification is required.

- Substance Use Disorder Services - inpatient services (including partial hospitalization/day treatment and residential treatment); intensive outpatient program treatment; psychological testing; outpatient treatment of opioid dependence; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; outpatient treatment provided in your home.

For a scheduled admission, you must notify us five business days before admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

In addition, you must notify us before the following services are received:

- Intensive outpatient program treatment.
- Outpatient electro-convulsive treatment.
- Psychological testing.
- Outpatient treatment of opioid dependence.
- Extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.
- Outpatient treatment provided in your home.

**Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)**

Effective April 1, 2009, the *Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)* expands special enrollment rights under the Policy.

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

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

- The Eligible Person and/or Dependent had existing health coverage under *Medicaid or Children's Health Insurance Program (CHIP)* at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period; and

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

- The Eligible Person previously declined coverage under the Policy, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under *Medicaid or Children's Health Insurance Program (CHIP)*. Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date of determination of subsidy eligibility.
Women's Health and Cancer Rights Act of 1998

As required by the Women's Health and Cancer Rights Act of 1998, Benefits under the Policy are provided for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments, 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 claim appeal procedures.

If you have prescription drug Benefits and are asked to pay the full cost of a prescription when you fill it at a retail or mail-order pharmacy, and if you believe that it should have been paid under the Policy, you may submit a claim for reimbursement in accordance with the applicable claim filing procedures. If you pay a Copayment and believe that the amount of the Copayment was incorrect, you also may submit a claim for reimbursement in accordance with the applicable claim filing procedures. When you have filed a claim, your claim will be treated under the same procedures for post-service group health plan claims as described in this section.

Pre-service Requests for Benefits

Pre-service requests for Benefits are those requests that require notification or approval prior to receiving medical care. If you have a pre-service request for Benefits, and it was submitted properly with all needed information, you will receive written notice of the decision from us within 15 days of receipt of the request. If you filed a pre-service request for Benefits improperly, we will notify you of the improper filing and how to correct it within five days after the pre-service request for Benefits was received. If additional information is needed to process the pre-service request, we will notify you of the information needed within 15 days after it was received, and may request a one time extension not longer than 15 days and pend your request until all information is received. Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, we will notify you of the determination within 15 days after the information is received. If you don’t provide the needed information within the 45-day period, your request for Benefits will be denied. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the appeal procedures.

If you have prescription drug Benefits and a retail or mail order pharmacy fails to fill a prescription that you have presented, you may file a pre-service health request for Benefits in accordance with the applicable claim filing procedure. When you have filed a request for Benefits, your request will be treated under the same procedures for pre-service group health plan requests for Benefits as described in this section.
Urgent Requests for Benefits that Require Immediate Attention

Urgent requests for Benefits are those that require notification or a benefit determination prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health, or the ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, could cause severe pain. In these situations, you will receive notice of the benefit determination in writing or electronically within 72 hours after we receive all necessary information, taking into account the seriousness of your condition.

If you filed an urgent request for Benefits improperly, we will notify you of the improper filing and how to correct it within 24 hours after the urgent request was received. If additional information is needed to process the request, we will notify you of the information needed within 24 hours after the request was received. You then have 48 hours to provide the requested information.

You will be notified of a benefit determination no later than 48 hours after:

- Our receipt of the requested information; or
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. We will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Questions or Concerns about Benefit Determinations

If you have a question or concern about a benefit determination, you may informally contact our Customer 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. 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 review of the first level appeal decision. The second level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures associated with urgent requests for Benefits, see *Urgent Appeals that Require Immediate Action* below.

If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to us within 60 days from receipt of the first level appeal decision.

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure. We don't determine whether the pending health service is necessary or appropriate. That decision is between you and your Physician.

**Urgent Appeals that Require Immediate Action**

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:
• The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.

• We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
Health Plan Notices of Privacy Practices

Medical Information Privacy Notice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

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 have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, we will provide to you a revised notice by direct mail or electronically as permitted by applicable law. In all cases, we will post the revised notice on our website www.myuhc.com. We reserve the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

*For purposes of this Notice of Privacy Practices, "we" or "us" refers to the following health plans that are affiliated with UnitedHealth Group:

How We Use or Disclose Information

We must use and disclose your health information to provide that information:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice; and
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected.

We have the right to use and disclose health information for your treatment, to pay for your health care and to operate our business. For example, we may use or disclose your health information:

- **For Payment** of premiums due us, to determine your coverage, and to process claims for health care services you receive, including for subrogation or coordination of other benefits you may have. For example, we may tell a doctor whether you are eligible for coverage and what percentage of the bill may be covered.

- **For Treatment.** We may use or disclose health information to aid in your treatment or the coordination of your care. For example, we may disclose information to your physicians or hospitals to help them provide medical care to you.

- **For Health Care Operations.** We may use or disclose health information as necessary to operate and manage our business activities related to providing and managing your health care coverage. For example, we might talk to your physician to suggest a disease management or wellness program that could help improve your health or we may analyze data to determine how we can improve our services.

- **To Provide You Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law.

- **For Plan Sponsors.** If your coverage is through an employer sponsored group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with federal law.

- **For Reminders.** We may use or disclose health information to send you reminders about your benefits or care, such as appointment reminders with providers who provide medical care to you.

We may use or disclose your health information for the following purposes under limited circumstances:

- **As Required by Law.** We may disclose information when required to do so by law.

- **To Persons Involved With Your Care.** We may use or disclose your health information to a person involved in your care or who helps pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interests.

- **For Public Health Activities** such as reporting or preventing disease outbreaks.

- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social service or protective service agency.

- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.
• **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.

• **For Law Enforcement Purposes.** We may disclose your health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.

• **To Avoid a Serious Threat to Health or Safety** to you, another person or the public by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.

• **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.

• **For Workers’ Compensation** as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.

• **For Research Purposes** such as research related to the evaluation of certain treatments or the prevention of disease or disability, if the research study meets privacy law requirements.

• **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.

• **For Organ Procurement Purposes.** We may use or disclose information to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.

• **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

• **To Business Associates** that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

• **For Data Breach Notification Purposes.** We may use your contact information to provide legally-required notices of unauthorized acquisition, access, or disclosure of your health information. We may send notice directly to you or provide notice to the sponsor of your plan through which you receive coverage.

**Additional Restrictions on Use and Disclosure**

Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. "Highly confidential information" may include confidential information under Federal laws governing alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information:

• HIV/AIDS;

• Mental health;

• Genetic tests;

• Alcohol and drug abuse;
Sexually transmitted diseases and reproductive health information; and

Child or adult abuse or neglect, including sexual assault.

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law. Attached to this notice is a summary of federal and state laws on use and disclosure of certain types of medical information.

Except for uses and disclosures described and limited as set forth in this notice, we will use and disclose your health information only with a written authorization from you. Once you give us authorization to release your health information, we cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or “revoke” your written authorization at anytime in writing, except if we have already acted based on your authorization. To find out where to mail your written authorization and how to revoke an authorization, contact the phone number listed on the back of your ID card.

What Are Your Rights

The following are your rights with respect to your health information:

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that authorize your dependents to request certain restrictions. Please note that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any restriction.

- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests where a disclosure of all or part of your health information otherwise could endanger you. We will accept verbal requests to receive confidential communications, but requests to modify or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.

- **You have the right to see and obtain a copy** of health information that may be used to make decisions about you such as claims and case or medical management records. You also may in some cases receive a summary of this health information. You must make a written request to inspect and copy your health information. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information. We may charge a reasonable fee for any copies. If we deny your request, you have the right to have the denial reviewed. If we maintain an electronic health record containing your health information, when and if we are required by law, you will have the right to request that we send a copy of your health information in an electronic format to you or to a third party that you identify. We may charge a reasonable fee for sending the electronic copy of your health information.

- **You have the right to ask to amend** information we maintain about you if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. If we deny your request, you may have a statement of your disagreement added to your health information.

- **You have the right to receive an accounting** of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) prior to April 14, 2003; (ii) for treatment, payment and health care operations purposes; (iii) to you or pursuant to your authorization; (iv) to correctional institutions or law enforcement officials; and (v) other disclosures for which federal law does not require us to provide an accounting.
You have the right to a paper copy of this notice. You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You also may obtain a copy of this notice at our website, www.myuhc.com.

Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want to exercise any of your rights, please call the toll-free phone number on the back of your ID card or you may contact the UnitedHealth Group Customer Call Center at 866-633-2446.

- **Submitting a Written Request.** Mail to us your written requests for modifying or cancelling a confidential communication, for copies of your records, or for amendments to your record, at the following address:

  UnitedHealthcare
  
  Customer Service - Privacy Unit
  
  PO Box 740815
  
  Atlanta, GA 30374-0815

- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the address listed above.

  You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. We will not take any action against you for filing a complaint.
Financial Information Privacy Notice

This notice describes how financial information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

Information We Collect

We collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age, medical information and Social Security number.
- Information about your transactions with us, our affiliates or others, such as premium payment and claims history.
- Information from consumer reports.

Disclosure of Information

We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law. For example, in the course of our general business practices, we may, as permitted by law, disclose any of the personal financial information that we collect about you, without your authorization, to the following types of institutions:

- To our corporate affiliates, which include financial service providers, such as other insurers, and non-financial companies, such as data processors.
- To nonaffiliated companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations.
- To nonaffiliated companies that perform services for us, including sending promotional communications on our behalf.

For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities listed on the first page of the Health Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliates: AmeriChoice Health Services, Inc.; DBP Services of New York IPA, Inc.; DCG Resource Options, LLC; Dental Benefit Providers, Inc.; Dental Benefit Providers of California, Inc.; Dental Benefit Providers of Illinois, Inc.; Disability Consulting Group, LLC; HealthAllies, Inc.; MAMSI Insurance Resources, LLC; Managed Physical Network, Inc.; Mid Atlantic Medical Services, LLC; National Pacific Dental, Inc.; Nevada Pacific Dental; OneNet PPO, LLC; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; PacifiCare Health Plan Administrators, Inc.; ProcessWorks, Inc.; Spectera, Inc.; Spectera of New York, IPA, Inc.; UMR, Inc.; Unimerica Insurance Company; Unimerica Life Insurance Company of New York; Unison Administrative Services, LLC; United Behavioral Health of New York 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.
Confidentiality and Security

We restrict access to personal financial information about you to our employees and service providers who are involved in administering your health care coverage and providing services to you. We maintain physical, electronic and procedural safeguards in compliance with state and federal standards to guard your personal financial information. We conduct regular audits to help ensure appropriate and secure handling and processing of our enrollees’ information.

Questions about this Notice

If you have any questions about this notice, please call the toll-free phone number on the back of your ID card or you may contact the UnitedHealth Group Customer Call Center at 866-633-2446.
UnitedHealth Group

Health Plan Notice of Privacy Practices: Federal and State Amendments

The first part of this Notice, which provides our privacy practices for Medical Information, describes how we may use and disclose your health information under federal privacy rules. There are other laws that may limit our rights to use and disclose your health information beyond what we are allowed to do under the federal privacy rules. The purpose of the charts below is to:

- Show the categories of health information that are subject to these more restrictive laws.
- Give you a general summary of when we can use and disclose your health information without your consent.

If your written consent is required under the more restrictive laws, the consent must meet the particular rules of the applicable federal or state law.

## Summary of Federal Laws

<table>
<thead>
<tr>
<th>Alcohol &amp; Drug Abuse Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>We are allowed to use and disclose alcohol and drug abuse information that is protected by federal law only (1) in certain limited circumstances, and/or disclose only (2) to specific recipients.</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Genetic Information</th>
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<tbody>
<tr>
<td>We are not allowed to use genetic information for underwriting purposes.</td>
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</table>

## Summary of State Laws

<table>
<thead>
<tr>
<th>General Health Information</th>
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</thead>
<tbody>
<tr>
<td>We are allowed to disclose general health information only (1) under certain limited circumstances, and/or (2) to specific recipients. CA, NE, PR, RI, VT, WA, WI</td>
</tr>
<tr>
<td>HMOs must give enrollees an opportunity to approve or refuse disclosures, subject to certain exceptions. KY</td>
</tr>
<tr>
<td>You may be able to restrict certain electronic disclosures of health information. NV</td>
</tr>
<tr>
<td>We are not allowed to use health information for certain purposes. CA</td>
</tr>
<tr>
<td>We will not use and/or disclose information regarding certain public assistance programs except for certain purposes. MO, NJ, SD</td>
</tr>
</tbody>
</table>

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<tr>
<th>Prescriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>We are allowed to disclose prescription-related information only (1) under certain limited circumstances, and/or (2) to specific recipients. ID, NH, NV</td>
</tr>
<tr>
<td><strong>Communicable Diseases</strong></td>
</tr>
<tr>
<td>--------------------------</td>
</tr>
<tr>
<td>We are allowed to disclose communicable disease information only (1) under certain limited circumstances, and/or (2) to specific recipients.</td>
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</table>

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<tr>
<th><strong>Sexually Transmitted Diseases and Reproductive Health</strong></th>
<th>CA, FL, HI, IN, KS, MI, MT, NJ, NV, PR, WA, WY</th>
</tr>
</thead>
<tbody>
<tr>
<td>We are allowed to disclose sexually transmitted disease and/or reproductive health information only (1) under certain limited circumstances and/or (2) to specific recipients.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Alcohol and Drug Abuse</strong></th>
<th>CT, GA, HI, KY, IL, IN, IA, LA, NC, NH, WA, WI</th>
</tr>
</thead>
<tbody>
<tr>
<td>We are allowed to use and disclose alcohol and drug abuse information (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.</td>
<td></td>
</tr>
<tr>
<td>Disclosures of alcohol and drug abuse information may be restricted by the individual who is the subject of the information.</td>
<td>WA</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Genetic Information</strong></th>
<th>CA, CO, HI, IL, KS, KY, LA, NY, RI, TN, WY</th>
</tr>
</thead>
<tbody>
<tr>
<td>We are not allowed to disclose genetic information without your written consent.</td>
<td></td>
</tr>
<tr>
<td>We are allowed to disclose genetic information only (1) under certain limited circumstances and/or (2) to specific recipients.</td>
<td>AK, AZ, FL, GA, IA, MD, MA, MO, NJ, NV, NH, NM, OR, RI, TX, UT, VT</td>
</tr>
<tr>
<td>Restrictions apply to (1) the use, and/or (2) the retention of genetic information.</td>
<td>FL, GA, IA, LA, MD, NM, OH, UT, VA, VT</td>
</tr>
</tbody>
</table>

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<tr>
<th><strong>HIV / AIDS</strong></th>
<th>AZ, AR, CA, CT, DE, FL, GA, HI, IA, IL, IN, KS, KY, ME, MI, MO, MT, NY, NC, NH, NM, NV, OR, PA, PR, RI, TX, VT, WA, WI, WV, WY</th>
</tr>
</thead>
<tbody>
<tr>
<td>We are allowed to disclose HIV/AIDS-related information only (1) under certain limited circumstances and/or (2) to specific recipients.</td>
<td></td>
</tr>
<tr>
<td>Certain restrictions apply to oral disclosures of HIV/AIDS-related information.</td>
<td>CT, FL</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th><strong>Mental Health</strong></th>
<th>CA, CT, DC, HI, IA, IL, IN, KY, MA, MI, NC, NM, PR, TN, WA, WI</th>
</tr>
</thead>
<tbody>
<tr>
<td>We are allowed to disclose mental health information only (1) under certain limited circumstances and/or (2) to specific recipients.</td>
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</tr>
<tr>
<td>Disclosures may be restricted by the individual who is the subject of the information.</td>
<td>WA</td>
</tr>
<tr>
<td>Certain restrictions apply to oral disclosures of mental health information.</td>
<td>CT</td>
</tr>
<tr>
<td>Certain restrictions apply to the use of mental health information.</td>
<td>ME</td>
</tr>
<tr>
<td>Child or Adult Abuse</td>
<td></td>
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<tr>
<td>---------------------</td>
<td></td>
</tr>
<tr>
<td>We are allowed to use and disclose child and/or adult abuse information only (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.</td>
<td></td>
</tr>
<tr>
<td>AL, CO, IL, LA, NE, NJ, NM, RI, TN, TX, UT, WI</td>
<td></td>
</tr>
</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 COBRA continuation rights. Review the Summary Plan Description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

You are entitled to a reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another group health plan. You should be provided a certificate of creditable coverage, in writing, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. You may request a certificate of creditable coverage by calling the number on the back of your ID card. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the
materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for Benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U. S. Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefits Security Administration.
ERISA Statement
If the Enrolling Group is subject to ERISA, the following information applies to you.

Summary Plan Description
Name of Plan: Educators Benefit Services, Inc. Welfare Benefit Plan
Name, Address and Telephone Number of Plan Sponsor and Named Fiduciary:

Educators Benefit Services, Inc.
890 Airport Park Rd
Suite 103
Glen Burnie, MD 21061
(410) 590-6548

The Plan Sponsor retains all fiduciary responsibilities with respect to the Plan except to the extent the Plan Sponsor has delegated or allocated to other persons or entities one or more fiduciary responsibilities with respect to the Plan.

Claims Fiduciary:

UnitedHealthcare Insurance Company

Employer Identification Number (EIN): 52-1642161

IRS Plan Number: 501

Effective Date of Plan: The effective date of the Plan is January 1, 2010; the effective date of this restatement of the Plan is January 1, 2013

Type of Plan: Health care coverage plan

Name, business address, and business telephone number of Plan Administrator:

Educators Benefit Services, Inc.
890 Airport Park Rd
Suite 103
Glen Burnie, MD 21061
(410) 590-6548

Type of Administration of the Plan:

Benefits are paid pursuant to the terms of a group health policy issued and insured by:

UnitedHealthcare Insurance Company
185 Asylum Street
Hartford, CT 06103-3408

The Plan is administered on behalf of the Plan Administrator by UnitedHealthcare Insurance Company pursuant to the terms of the group Policy. UnitedHealthcare Insurance Company provides administrative services for the Plan including claims processing, claims payment, and handling appeals.

Person designated as agent for service of legal process: Plan Administrator:

Source of contributions and funding under the Plan: There are no contributions to the Plan. Any required employee contributions are used to partially reimburse the Plan Sponsor for Premiums under the Plan. Benefits under the Plan are funded by the payment of Premium required by the group Policy.
**Method of calculating the amount of contribution:** Employee-required contributions to the Plan Sponsor are the employee's share of costs as determined by Plan Sponsor. From time to time, the Plan Sponsor will determine the required employee contributions for reimbursement to the Plan Sponsor and distribute a schedule of such required contributions to employees.

**Date of the end of the year for purposes of maintaining Plan's fiscal records:**

Plan year shall be a 12 month period ending January 1.

**Determinations of Qualified Medical Child Support Orders:** The plan's procedures for handling qualified medical child support orders are available without charge upon request to the Plan Administrator.