Evidence of Coverage

State of Maryland
Choice Plus PPO Plan

Effective: January 1, 2016 through December 31, 2016
Group Number: 716450

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SECTION 1 - WELCOME

Quick Reference Box

- Member services, claim inquiries, Care Coordination and Mental Health/Substance Use Disorder Administrator: (800) 382-7513;
- Claims submittal address: UnitedHealthcare - Claims, P.O. Box 740800, Atlanta, GA 30374-0800; and
- Online assistance: **www.myuhc.com**.

State of Maryland is pleased to provide you with this Evidence of Coverage (EOC), which describes the health Benefits available to you and your eligible dependents. It includes summaries of:

- who is eligible;
- services that are covered, called Covered Health Services;
- services that are not covered, called Exclusions;
- how Benefits are paid; and
- your rights and responsibilities under the Plan.

This EOC is designed to meet your information needs. It supersedes any previous printed or electronic EOC for this Plan.

IMPORTANT

The healthcare service, supply or Pharmaceutical Product is only a Covered Health Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Service in Section 14, *Glossary*.) The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance use disorder, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Service under the Plan.

State of Maryland intends to continue this Plan, but reserves the right, in its sole discretion, to modify, change, revise, amend or terminate the Plan at any time, for any reason, and without prior notice. This EOC is not to be construed as a contract of or for employment. If there should be an inconsistency between the contents of this summary and the contents of the Plan, your rights shall be determined under the Plan and not under this summary.

UnitedHealthcare is a private healthcare claims administrator. UnitedHealthcare's goal is to give you the tools you need to make wise healthcare decisions. UnitedHealthcare also helps the State of Maryland to administer claims. Although UnitedHealthcare will assist you in many ways, it does not guarantee any Benefits. State of Maryland is solely responsible for paying Benefits described in this EOC.

Please read this EOC thoroughly to learn how the Plan works. If you have questions contact your local Agency Benefit Coordinator or the Employee Benefits Division or call the number on the back of your ID card.

How To Use This Evidence of Coverage

- Read the entire EOC, and share it with your eligible dependents. Then keep it in a safe place for future reference.
- Many of the sections of this EOC are related to other sections. You may not have all the information you need by reading just one section.
- You can find copies of your EOC and any future amendments or request printed copies by contacting your Agency Benefit Coordinator or the Employee Benefits Division.
- Capitalized words in the EOC have special meanings and are defined in Section 14, *Glossary*.
- If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in Section 14, *Glossary*.
- State of Maryland is also referred to as Group.

SECTION 2 - INTRODUCTION

What this section includes:

- Who's eligible for coverage under the Plan;
- The factors that impact your cost for coverage;
- Instructions and timeframes for enrolling yourself and your eligible Dependents;
- When coverage begins; and
- When you can make coverage changes under the Plan.

Eligibility

You are eligible to enroll in the Plan if you are an active state employee, contractual employee, satellite employee or retiree who meets the Group's eligibility criteria.

Your eligible Dependents may also participate in the Plan. An eligible Dependent is considered to be:

- your Spouse, as defined in Section 14, *Glossary*;
- your or your Spouse's child who is under age 26, including a natural child, stepchild, grandchild, a legally adopted child, a child placed for adoption or a child for whom you or your Spouse are the legal guardian;
- an unmarried child who is or becomes disabled prior to turning age 26 and is or becomes dependent upon you; or
- a child who meets the State of Maryland definition of a Dependent.

Note: Your Dependents may not enroll in the Plan unless you are also enrolled. In addition, if you and your Spouse are both covered under the Plan, you may each be enrolled as an Employee or be covered as a Dependent of the other person, but not both. In addition, if you and your Spouse are both covered under the Plan, only one parent may enroll your child as a Dependent.

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, as described in Section 13, *Other Important Information*.

Cost of Coverage

You and State of Maryland share in the cost of the Plan. Your contribution amount depends on the Plan you select and the eligible dependents you choose to enroll.

For active state employees, your contributions are deducted from your paychecks on a before-tax basis in most cases. Before-tax dollars come out of your pay before federal income and Social Security taxes are withheld - and in most states, before state and local

taxes are withheld. This gives your contributions a special tax advantage and lowers the actual cost to you.

Your contributions are subject to review and State of Maryland reserves the right to change your contribution amount from time to time. You can obtain your current rate contributions by going to the Department of Budget & Management Employee Benefits Division's website at www.dbm.maryland.gov/benefits.

How to Enroll

To enroll, contact your Agency Benefit Coordinator within 60 days of the date you first become eligible for medical Plan coverage. If you do not enroll within 60 days, you will need to wait until the next annual Open Enrollment to make your benefit elections unless you experience a family status change.

Each year during annual Open Enrollment, you have the opportunity to review and change your medical election. Any changes you make during Open Enrollment will become effective the beginning of the plan year.

Important
If you wish to change your benefit elections following your marriage, birth, adoption of a child, placement for adoption of a child or other family status change, you must contact your Agency Benefit Coordinator (for active state employees, contractual employees, and satellite employees) or the Employee Benefits Division (for retirees) within 60 days of the event. Otherwise, you will need to wait until the next annual Open Enrollment to change your elections.

When Coverage Begins

Once the Employee Benefits Division receives your properly completed enrollment, coverage will begin either the first or 16th of the month, based on the pay period in which the first deduction is taken. Coverage for your Dependents will start on the date your coverage begins, provided you have enrolled them in a timely manner. For newly retired employees, coverage begins the first of the month.

Coverage for a Spouse or Dependent stepchild that you acquire via marriage becomes effective the first or 16th of the month based on the pay period in which the first deduction is taken, provided you notify your Agency Benefit Coordinator (for active state employees, contractual employees, and satellite employees) or the Employee Benefits Division (for retirees) within 60 days of your marriage. Coverage for Dependent children acquired through adoption or placement for adoption is effective the date of the family status change only if you have requested a retroactive adjustment, otherwise either the first or 16th of the month based on the pay period in which the first deduction is taken provided you notify your Agency Benefit Coordinator (for active state employees, contractual employees, and satellite employees) or the Employee Benefits Division (for retirees) within 60 days of the birth, adoption, or placement.

A newborn will not be covered until enrolled. The newborn must be enrolled with the Plan within 60 days of birth to have coverage back to birth. Once confirmation of enrollment has been received that the newborn has been enrolled claims will be resubmitted or reprocessed.

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, the Plan will pay Benefits for Covered Health Services related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Plan.

You should notify UnitedHealthcare within 48 hours of the day your stay begins, or as soon as is reasonably possible. In-Network Benefits are available only if you receive Covered Health Services from In-Network providers.

Changing Your Coverage

You may make coverage changes during the year only if you experience a change in family status. The change in coverage must be consistent with the change in status (e.g., you cover your Spouse following your marriage, your child following an adoption, etc.). The following are considered family status changes for purposes of the Plan:

- your marriage or divorce;
- the birth, adoption, placement for adoption or legal guardianship of a child;
- a change in your Spouse's employment or involuntary loss of health coverage (other than coverage under the Medicare or Medicaid programs) under another employer's plan;
- loss of coverage due to the exhaustion of another employer's COBRA benefits, provided you were paying for premiums on a timely basis;
- the death of a Dependent;
- your Dependent child no longer qualifying as an eligible Dependent;
- a change in your or your Spouse's position or work schedule that impacts eligibility for health coverage;
- contributions were no longer paid by the employer (This is true even if you or your eligible Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer);
- you or your eligible Dependent who were enrolled in an HMO no longer live or work in that HMO's service area and no other benefit option is available to you or your eligible Dependent;
- benefits are no longer offered by the Plan to a class of individuals that include you or your eligible Dependent;

- termination of your or your Dependent's Medicaid or State Children's Health Insurance Program (CHIP) coverage as a result of loss of eligibility (you must contact your Agency Benefit Coordinator or the Employee Benefits Division within 60 days of termination);
- you or your Dependent become eligible for a premium assistance subsidy under Medicaid or CHIP (you must contact your Agency Benefit Coordinator or the Employee Benefits Division within 60 days of determination of subsidy eligibility);
- a strike or lockout involving you or your Spouse; or
- a court or administrative order.

Unless otherwise noted above, if you wish to change your elections, you must contact your Agency Benefit Coordinator or the Employee Benefits Division within 60 days of the change in family status. Otherwise, you will need to wait until the next annual Open Enrollment.

While some of these changes in status are similar to qualifying events under COBRA, you, or your eligible Dependent, do not need to elect COBRA continuation coverage to take advantage of the special enrollment rights listed above. These will also be available to you or your eligible Dependent if COBRA is elected.

Note: Any child under age 26 who is placed with you for adoption will be eligible for coverage on the date the child is placed with you, even if the legal adoption is not yet final. If you do not legally adopt the child, all medical Plan coverage for the child will end when the placement ends. No provision will be made for continuing coverage (such as COBRA coverage) for the child.

Change in Family Status - Example
Jane is married and has two children who qualify as Dependents. At annual Open Enrollment, she elects not to participate in State of Maryland's medical plan, because her husband, Tom, has family coverage under his employer's medical plan. In June, Tom loses his job as part of a downsizing. As a result, Tom loses his eligibility for medical coverage. Due to this family status change, Jane can elect family medical coverage under State of Maryland's medical plan outside of annual Open Enrollment.

SECTION 3 - HOW THE PLAN WORKS

What this section includes:

- State of Maryland Wellness Program;
- Accessing In-Network and Out-of-Network Benefits;
- Eligible Expenses;
- Annual Deductible;
- Copayment;
- Coinsurance; and
- Out-of-Pocket Maximum.

State of Maryland Wellness Program*

The State of Maryland Wellness Program will help all State employees, non-Medicare eligible retirees and enrolled spouses complete the State's required wellness program (children are not eligible to participate, regardless of age). The Wellness Program will require employees, non-Medicare eligible retirees and enrolled spouses who did not previously complete in 2015 to complete healthy activities throughout the 2016 calendar year. Once these activities are completed, enrollees will enjoy enhanced benefits such as waiving copays for all Primary Care Physician (PCP) visits.

2016 HEALTHY ACTIVITIES - January 1, 2016 - September 30, 2016
All Eligible Participants who did not already complete activities in 2015
1. Select a primary care provider (PCP) if not already done. You can designate your PCP using the Provider Notification Form. The Provider Notification Form can be located under the "Rewards" tab of the Rally health and wellness website under your "Call to Action" section. 2. Complete Health Assessment – You have two options to choose from on **www.myuhc.com:** ♦ Complete the Rally℠ Health Assessment that can be located on the Health and Wellness tab and click "Go to Rally" OR ♦ Complete the State of Maryland's Health Assessment that can be located on the Claims & Accounts tab in the Claim Forms section. 3. Review your health assessment results with your selected PCP, who will then sign the Provider Notification Form confirming review. 4. Submit the Provider Notification Form to: Customer Elation, Attn: Biometrics Team, 1150 5th SE, Hutchinson, MN 55350. You may also fax to 1(855) 230-7161 or electronically upload it by visiting **www.myuhc.com**.

Get Rewarded!

Upon completion of Step 1 - 4 of your Health Activities, you and your spouse will have your PCP copays waived, starting the following month.

* Retirees and retirees' spouses for whom Medicare is primary are not eligible to participate, nor are enrolled children even if they are adults.

Accessing In-Network and Out-of-Network Benefits

As a participant in this Plan, you have the freedom to choose the Physician or health care professional you prefer each time you need to receive Covered Health Services. The choices you make affect the amounts you pay, as well as the level of Benefits you receive and any benefit limitations that may apply.

You are eligible for the In-Network level of Benefits under this Plan when you receive Covered Health Services from Physicians and other health care professionals who have contracted with UnitedHealthcare to provide those services.

You can choose to receive In-Network Benefits or Out-of-Network Benefits.

In-Network Benefits apply to Covered Health Services that are provided by an In-Network Physician or other In-Network provider. Emergency Health Services are always paid as In-Network Benefits. For facility charges, these are Benefits for Covered Health Services that are billed by an In-Network facility and provided under the direction of either an In-Network or Out-of-Network Physician or other provider. In-Network Benefits include Physician services provided in an In-Network facility by an In-Network or an Out-of-Network radiologist, anesthesiologist, pathologist and Emergency room Physician.

Out-of-Network Benefits apply to Covered Health Services that are provided by an Out-of-Network Physician or other Out-of-Network provider, or Covered Health Services that are provided at an Out-of-Network facility.

Generally, when you receive Covered Health Services from an In-Network provider, you pay less than you would if you receive the same care from an Out-of-Network provider. Therefore, in most instances, your out-of-pocket expenses will be less if you use an In-Network provider.

If you choose to seek care outside the Network, the Plan generally pays Benefits at a lower level. You are required to pay the amount that exceeds the Eligible Expense. The amount in excess of the Eligible Expense could be significant, and this amount does not apply to the Out-of-Pocket Maximum. You may want to ask the Out-of-Network provider about their billed charges before you receive care. Emergency services received at an Out-of-Network Hospital are covered at the In-Network level.

Health Services from Out-of-Network Providers Paid as In-Network Benefits

If specific Covered Health Services are not available from an In-Network provider, you may be eligible to receive In-Network Benefits from an Out-of-Network provider. In this situation, your In-Network Physician will notify the Claims Administrator and if the Claims Administrator confirms that care is not available from an In-Network provider, the Claims Administrator will work with you and your In-Network Physician to coordinate care through an Out-of-Network provider.

Looking for an In-Network Provider?
In addition to other helpful information, **www.myuhc.com,** UnitedHealthcare's consumer website, contains a directory of health care professionals and facilities in UnitedHealthcare's Network. While In-Network status may change from time to time, **www.myuhc.com** has the most current source of In-Network information. Use **www.myuhc.com** to search for Physicians available in your Plan.

In-Network Providers

UnitedHealthcare or its affiliates arrange for health care providers to participate in a Network. To verify a provider's status or to locate a participating provider, you can call UnitedHealthcare at the toll-free number on your ID card or log onto **www.myuhc.com**.

In-Network providers are independent practitioners and are not employees of State of Maryland or UnitedHealthcare.

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

Possible Limitations on Provider Use

If UnitedHealthcare determines that health care services are being used in a harmful or abusive manner, UnitedHealthcare has the right to select an In-Network Physician to coordinate all of your future Covered Health Services. If you don't make a selection within 31 days of the date you are notified, UnitedHealthcare has the right to select an In-Network Physician for you. In the event that you do not use the In-Network Physician to coordinate all of your care, any Covered Health Services you receive may be paid at the Out-of-Network level.

Eligible Expenses

State of Maryland has delegated to UnitedHealthcare the initial discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.

Eligible Expenses are the amount UnitedHealthcare determines that UnitedHealthcare will pay for Benefits. For In-Network Benefits, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For In-Network Benefits for Covered Health Services provided by an Out-of-Network provider (other than Emergency Health Services or services otherwise arranged by UnitedHealthcare), you will be responsible to the Out-of-Network Physician or provider for any amount billed that is greater than the amount UnitedHealthcare determines to be an Eligible Expense as described below. For

Out-of-Network Benefits, you are responsible for paying, directly to the Out-of-Network provider, any difference between the amount the provider bills you and the amount UnitedHealthcare will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines, as described in the SPD.

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

- When Covered Health Services are received from an In-Network provider, Eligible Expenses are UnitedHealthcare's contracted fee(s) with that provider.
- When Covered Health Services are received from an Out-of-Network provider as a result of an Emergency or as arranged by UnitedHealthcare, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Out-of-Network Benefits, Eligible Expenses are based on either of the following:

- When Covered Health Services are received from an Out-of-Network provider, Eligible Expenses are determined, based on:
  - Negotiated rates agreed to by the Out-of-Network provider and either UnitedHealthcare or one of UnitedHealthcare's vendors, affiliates or subcontractors, at UnitedHealthcare's discretion.
  - If rates have not been negotiated, then one of the following amounts:
    - ♦ Eligible Expenses are determined based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market, with the exception of the following:
      - 50% of *CMS* for the same or similar laboratory service.
      - 45% of *CMS* for the same or similar durable medical equipment, or CMS competitive bid rates.

- When a rate is not published by *CMS* for the service, UnitedHealthcare uses an available gap methodology to determine a rate for the service as follows:
  - For services other than Pharmaceutical Products, UnitedHealthcare uses a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale(s) currently in use become no longer available, UnitedHealthcare will use a comparable scale(s). UnitedHealthcare and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to UnitedHealthcare's website at **www.myuhc.com** for information regarding the vendor that provides the applicable gap fill relative value scale information.
  - For Pharmaceutical Products, UnitedHealthcare uses gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems*, *Thomson Reuters* (published

in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.
- When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, the Eligible Expense is based on 50% of the provider's billed charge.

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

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

- When Covered Health Services are received from an In-Network provider, Eligible Expenses are UnitedHealthcare's contracted fee(s) with that provider.

Don't Forget Your ID Card
Remember to show your UnitedHealthcare ID card every time you receive health care services from a provider. If you do not show your ID card, a provider has no way of knowing that you are enrolled under the Plan.

Annual Deductible

The Annual Deductible is the amount of Eligible Expenses you must pay each calendar year for Covered Health Services before you are eligible to begin receiving Benefits. The Annual Deductible applies only to Out-of-Network Benefits for this Plan. The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year and will be applied toward your out-of-pocket maximum.

Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum benefit limit. As a result, the limited benefit will be reduced by the number of days or visits you used toward meeting the Annual Deductible.

Any amount you pay for medical expenses in the last three months of the previous calendar year, that is applied to the previous Deductible, will be carried over and applied to the current Deductible. This carry-over feature applies to the individual and family Deductible.

Copayment

A Copayment (Copay) is the amount you pay each time you receive certain Covered Health Services. The Copay is a flat dollar amount and is paid at the time of service or when billed by the provider. Copays count toward the Copay Out-of-Pocket-Maximum. Copays do not count toward the Annual Deductible. If the Eligible Expense is less than the Copay, you are only responsible for paying the Eligible Expense and not the Copay.

Coinsurance

Coinsurance is the percentage of Eligible Expenses that you are responsible for paying. Coinsurance is a fixed percentage that applies to certain Covered Health Services after you meet the Annual Deductible.

Coinsurance - Example
Let's assume that you receive Plan Benefits for outpatient surgery from an Out-of-Network provider. Since the Plan pays 70% after you meet the Annual Deductible, you are responsible for paying the other 30%. This 30% is your Coinsurance.

Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum is the most you pay each calendar year for Covered Health Services. There are separate In-Network and Out-of-Network Out-of-Pocket Maximums for this Plan. If your eligible out-of-pocket expenses in a calendar year exceed the annual maximum, the Plan pays 100% of Eligible Expenses for Covered Health Services for the remainder of the calendar year.

Eligible Expenses charged by both In-Network and Out-of-Network providers apply toward both the In-Network individual and family Out-of-Pocket Maximums and the Out-of-Network individual and family Out-of-Pocket Maximums.

Copayments have a separate Out-of-Pocket Maximum.

The following table identifies what does and does not apply toward your In-Network and Out-of-Network Out-of-Pocket Maximums:

Plan Features	Applies to the In-Network Out-of-Pocket Maximum?	Applies to the Out-of-Network Out-of-Pocket Maximum?
Copays Separate Out of Pocket Maximum	No	No
Payments toward the Annual Deductible	N/A	Yes
Coinsurance Payments	Yes	Yes
Charges for non-Covered Health Services	No	No
The amounts of any reductions in Benefits you incur by not obtaining prior authorization as required	No	No
Charges that exceed Eligible Expenses	No	No

How the Plan Works - Example

The following example illustrates how Annual Deductibles, Copays, Out-of-Pocket Maximums and Coinsurance work in practice.

Let's say Gary has individual coverage under the Plan. He has not met his Out-of-Network Annual Deductible and needs to see a Physician. The flow chart below shows what happens when he visits an In-Network Primary Care Physician versus an Out-of-Network Primary Care Physician.

In-Network Benefits	Out-of-Network Benefits
1. Gary goes to see an In-Network Primary Care Physician and presents his ID card.	1. Gary goes to see an Out-of-Network Primary Care Physician and presents his ID card.
2. He receives treatment from the Primary Care Physician. The Plan's Eligible Expense for the In-Network office visit equals $125.	2. He receives treatment from the Primary Care Physician. The Eligible Expense for his visit is $175, however the Physician's fee is $225.
3. On his way out, Gary pays a $15 Copay. Since In-Network Physician office visits are covered at 100% after the Copay, Gary has met his financial obligations for this office visit.	3. The Physician's office requests no payment, informing Gary that it will bill UnitedHealthcare directly.*
4. The Plan pays $110 ($125 Eligible Expense minus $15 Copay).	4. Gary is responsible for paying the Eligible Expense of $175 directly to the Physician, because he has not yet met his Annual Deductible.
	5. Gary receives a bill from the Physician, and pays the Physician directly.
	6. The Physician's office, at its discretion, might bill Gary for the remaining $50:
	$225 (Physician's fee) - $175 (Eligible Expense) = $50
	Gary's $50 payment does not apply to his Annual Deductible or Out-of-Pocket Maximum.
	7. UnitedHealthcare applies the $175 toward Gary's Annual Deductible and Out-of-Pocket Maximum.

*Although Out-of-Network providers have the right to request payment in full at the time of service, they bill UnitedHealthcare directly in most cases but there could be instances where you must file your own claim.

SECTION 4 - CARE COORDINATION AND PRIOR AUTHORIZATION

What this section includes:

- An overview of the Care Coordination program; and
- Covered Health Services which Require Prior Authorization.

Care Management

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

UnitedHealthcare provides a program called Care Coordination designed to encourage personalized, efficient care for you and your covered Dependents.

Care Coordination Nurses center their efforts on prevention, education, and closing any gaps in your care. The goal of the program is to ensure you receive the most appropriate and cost-effective services available.

If you are living with a chronic condition or dealing with complex health care needs, UnitedHealthcare may assign to you a primary nurse, referred to as a Care Coordination Nurse to guide you through your treatment. This assigned nurse will answer questions, explain options, identify your needs, and may refer you to specialized care programs. The Care Coordination Nurse will provide you with their telephone number so you can call them with questions about your conditions, or your overall health and well-being.

Care Coordination Nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components are subject to change without notice.

If you do not receive a call from a Care Coordination Nurse but feel you could benefit from any of these programs, please call the toll-free number on your ID card.

Prior Authorization

UnitedHealthcare requires prior authorization for certain Covered Health Services. In general, Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. However, if you choose to receive Covered Health Services from an Out-of-Network provider, you are responsible for obtaining prior authorization before you receive the services. There are some In-Network Benefits, however, for which you are responsible for obtaining authorization before you receive the services. Services for which prior authorization is required are identified below and in Section 6, *Additional Coverage Details* within each Covered Health Service category.

It is recommended that you confirm with the Claims Administrator that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from an In-Network provider, you may want to contact the Claims Administrator to verify that the Hospital, Physician and other providers are In-Network providers and that they have obtained the required prior authorization. In-Network facilities and In-Network providers cannot bill you for services they fail to prior authorize as required. You can contact the Claims Administrator by calling the toll-free telephone number on the back of your ID card.

When you choose to receive certain Covered Health Services from Out-of-Network providers, you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when an Out-of-Network provider intends to admit you to an In-Network facility or refers you to other In-Network providers.

To obtain prior authorization, call the toll-free telephone number on the back of your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

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

Covered Health Services which Require Prior Authorization

In-Network providers are generally responsible for obtaining prior authorization from the Claims Administrator or contacting Care Coordination before they provide certain services to you. However, there are some services that you are responsible for obtaining prior authorization from the Claims Administrator.

In many cases, your Out-of-Network Benefits will be reduced if the Claims Administrator has not provided prior authorization. See Section 6, *Additional Coverage Details* for additional information on your requirements for prior authorization with each Covered Health Service.

The services that require you to obtain prior authorization from the Claims Administrator are:

- Ambulance - non-emergent air, In-Network and Out-of-Network.
- Clinical Trials, In-Network and Out-of-Network.
- Cochlear implants, Out-of-Network.
- Congenital Heart Disease surgery, Out-of-Network.

- Durable Medical Equipment for items that will cost more than $1,000 to purchase or rent, including diabetes equipment for the management and treatment of diabetes, Out-of-Network.
- Genetic Testing – BRCA, Out-of-Network.
- Home health care, Out-of-Network.
- Hospice care – inpatient, Out-of-Network.
- Hospital Inpatient Stay- all scheduled admissions and maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery, Out-of-Network.
- Lab, X-Ray and Diagnostics - Outpatient - sleep studies, Out-of-Network.
- Mental Health Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); 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, Out-of-Network.
- Neurobiological Disorders - Autism Spectrum Disorder Services - inpatient services (including Partial Hospitalization/Day treatment and services at a Residential Treatment Facility); 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, Out-of-Network. Pre-service notification is also required for Benefits provided for Applied Behavioral Analysis (ABA).
- Obesity surgery, Out-of-Network.
- Prosthetic Devices for items that will cost more than $1,000 to purchase or rent, Out-of-Network.
- Reconstructive Procedures, including breast reconstruction surgery following mastectomy and breast reduction surgery, Out-of-Network.
- Rehabilitation services - physical therapy and occupational therapy after the sixth visit; and all cardiac rehabilitation therapy and speech therapy visits, Out-of-Network.
- Skilled Nursing Facility/Inpatient Rehabilitation Facility Services, Out-of-Network.
- Substance Use Disorder Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); 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, Out-of-Network.
- Surgery - sleep apnea surgeries as described under *Surgery - Outpatient* in Section 6, *Additional Coverage Details*, Out-of-Network.
- Temporomandibular joint services, Out-of-Network.

- Therapeutics - all outpatient therapeutics as described under *Therapeutic Treatments - Outpatient* in Section 6, *Additional Coverage Details*, Out-of-Network.
- Transplants, In-Network and Out-of-Network.

Notification is required within 48 hours of admission or on the same day of admission if reasonably possible after you are admitted to an Out-of-Network Hospital as a result of an Emergency.

For prior authorization timeframes, and reductions in Benefits that apply if you do not obtain prior authorization from the Claims Administrator, see Section 6, *Additional Coverage Details*.

Contacting the Claims Administrator or Care Coordination is easy.
Simply call the toll-free number on your ID card.

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

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

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis and Medicare pays benefits before the Plan, you are not required to receive prior authorization from the Claims Administrator before receiving Covered Health Services. Since Medicare pays benefits first, the Plan will pay Benefits second as described in Section 10, *Coordination of Benefits (COB)*.

When Medicare is primary, the following are waived:

- Copayments; and
- Care Coordination prior authorization requirements.

SECTION 5 - PLAN HIGHLIGHTS

What this section includes:

- The table below provides an overview of Copays that apply when you receive certain Covered Health Services, and outlines the Plan's Annual Deductible and Out-of-Pocket Maximum.

Plan Features	In-Network	Out-of-Network
Copays[1]		
■ Emergency Health Services	$150 copay	$150 copay
■ Physician's Office Services - Primary Care Physician	$15 copay	70% of the allowed benefit after you meet the Annual Deductible
■ Physician's Office Services - Specialist	$30 copay	70% of the allowed benefit after you meet the Annual Deductible
■ Rehabilitation Services for Occupational, Physical and Speech Therapy – Limited to 50 days per year.	$30 copay	70% of the allowed benefit after you meet the Annual Deductible
■ Urgent Care Center Services	$30 copay	70% of the allowed benefit after you meet the Annual Deductible
Annual Deductible[2]		
■ Individual	N/A	$250
■ Family (not to exceed the applicable Individual amount per Covered Person)	N/A	$500
Annual Coinsurance Out-of-Pocket Maximum[2]		
■ Individual	$1,000	$3,000
■ Family (not to exceed the applicable Individual amount per Covered Person)	$2,000	$6,000

Plan Features	In-Network	Out-of-Network
Annual Copayment Out-of-Pocket Maximum[3]		
■ Individual Copay Maximum	$1,000	N/A
■ Family Copay Maximum	$2,000	N/A
Total Medical Out-of-Pocket Maximum		
■ Individual	$2,000	$3,250
■ Family (not to exceed the applicable Individual amount per Covered Person)	$4,000	$6,500
Lifetime Maximum Benefit[4]		
There is no dollar limit to the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan.	Unlimited	

[1]In addition to these Copays, you may be responsible for meeting the Annual Deductible for the Covered Health Services described in the chart on the following pages. With the exception of Emergency Health Services, a Copay does not apply when you visit an Out-of-Network provider.

[2]Copays do not apply toward the Annual Deductible and only apply to the Copay Out-of-Pocket Maximum. The Annual Deductible applies toward the Coinsurance Out-of-Pocket Maximum. In-Network and Out-of-Network Out-of-Pocket Maximums cross apply.

[3]Copays have a separate out-of-pocket maximum.

[4]Generally the following are considered to be essential benefits under the Patient Protection and Affordable Care Act:
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.

This table provides an overview of the Plan's coverage levels. For detailed descriptions of your Benefits, refer to Section 6, *Additional Coverage Details*.

Covered Health Services[1] See page 33 for explanation	**Percentage of Eligible Expenses Payable by the Plan:**	
	In-Network	**Out-of-Network**
Acupuncture Services **(for chronic pain management only)** (Copay is per visit)	100% of the allowed benefit after you pay a $30 Copay	70% of the allowed benefit after you meet the Annual Deductible
Allergy Care/Testing		
■ Physician's Office Services - Primary Care Physician (Copay is per visit)	100% of the allowed benefit after you pay a $15 Copay	70% of the allowed benefit after you meet the Annual Deductible
■ Physician's Office Services - Specialist (Copay is per visit)	100% of the allowed benefit after you pay a $30 Copay	70% of the allowed benefit after you meet the Annual Deductible
■ Allergy injection with no Physician's office visit.	100% of the allowed benefit	70% of the allowed benefit after you meet the Annual Deductible
Ambulance Services (Medical Emergency and Non-Emergency)		
■ Medical Emergency Ambulance	100% of the allowed benefit	100% of the allowed benefit
■ Non-Emergency Ambulance An example of Non-Emergency Ambulance would be transferring someone from one medical facility to another.	90% of the allowed benefit	70% of allowed benefit after you meet the Annual Deductible

Covered Health Services[1] See page 33 for explanation	Percentage of Eligible Expenses Payable by the Plan:	
	In-Network	**Out-of-Network**
Amino Acid-Based Elemental Formula	90% of the allowed benefit	70% of the allowed benefit after you meet the Annual Deductible
Cancer Resource Services (CRS)[2] See page 34 for explanation ■ Hospital Inpatient Stay	90% of the allowed benefit	Not Covered
Chiropractic Treatment	100% of the allowed benefit after a $30 Copay	70% of the allowed benefit after you meet the Annual Deductible
Cleft Lip/Palate	90% of the allowed benefit	70% of the allowed benefit after you meet the Annual Deductible
Clinical Trials	Depending upon where the Covered Health Service is provided, Benefits for Clinical Trials will be the same as those stated under each Covered Health Service category in this section.	
Congenital Heart Disease (CHD) Surgeries ■ Hospital - Inpatient Stay (If services are received at a Designated Facility)	90% of the allowed benefit	70% of the allowed benefit after you meet the Annual Deductible

Covered Health Services[1] See page 33 for explanation	Percentage of Eligible Expenses Payable by the Plan:	
	In-Network	**Out-of-Network**
Dental Services - Accident Only (Copay is per visit)	100% of the allowed benefit after you pay a $30 Copay	70% of the allowed benefit after you meet the Annual Deductible
Diabetes Services		
Diabetes Self-Management and Training/ Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be paid the same as those stated under each Covered Health Service category in this section.	
Diabetes Self-Management Items ■ insulin pumps ■ diabetes supplies	Benefits for diabetes equipment will be the same as those stated under *Durable Medical Equipment* in this section.	
■ diabetic test strips that work in conjunction with a glucometer	100% of the allowed benefit	70% of the allowed benefit after you meet the Annual Deductible
Durable Medical Equipment (DME)		
■ Breast Pumps & Breast Pump Supplies	100% of the allowed benefit	Not Covered
■ All other Durable Medical Equipment	90% of the allowed benefit	70% of the allowed benefit after you meet the Annual Deductible

Covered Health Services[1] See page 33 for explanation	Percentage of Eligible Expenses Payable by the Plan:	
	In-Network	**Out-of-Network**
Emergency Health Services - Outpatient		
■ Medical Emergency (Copay is per visit)	100% of the allowed benefit after you pay a $150 Copay	
■ Non-Emergency (Copay is per visit) Non-Emergency Services would be services that do not meet the definition of Medical Emergency or Emergency Services as defined in Section 14, *Glossary*. If you are admitted as an inpatient to a Hospital directly from the Emergency room, you will not have to pay this Copay. The Benefits for an Inpatient Stay in a Hospital will apply instead.	50% of the allowed benefit after you pay a $150 Copay	
■ Observation – up to 23 hours and 59 minutes – presented via Emergency Department (Copay is per visit)	100% of the allowed benefit after you pay a $150 Copay	70% of the allowed benefit after you meet the Annual Deductible
■ Observation – 24 hours or more presented via the Emergency Department	90% of the allowed benefit	70% of the allowed benefit after you meet the Annual Deductible
Family Planning	Coverage level depends on covered service provided	Coverage level depends on covered service provided
Hearing Care		
■ Physician's Office Services - Primary Care Physician (Copay is per visit)	100% of the allowed benefit after you pay a $15 Copay	70% of the allowed benefit after you meet the Annual Deductible
■ Physician's Office Services - Specialist (Copay is per visit) See Section 6, *Additional Coverage Details*, for limits.	100% of the allowed benefit after you pay a $30 Copay	70% of the allowed benefit after you meet the Annual Deductible

Covered Health Services[1] See page 33 for explanation	Percentage of Eligible Expenses Payable by the Plan:	
	In-Network	**Out-of-Network**
Hearing Aids Basic model only	100% of the allowed benefit	70% of the allowed benefit after you meet the Annual Deductible
Home Health Care See Section 6, *Additional Coverage Details*, for limits.	90% of the allowed benefit	70% of the allowed benefit after you meet the Annual Deductible
Hospice Care	90% of the allowed benefit	70% of the allowed benefit after you meet the Annual Deductible
Hospital - Inpatient Stay	90% of the allowed benefit	70% of the allowed benefit after you meet the Annual Deductible
Infertility Services		
■ Physician's Office Services - Primary Care Physician (Copay is per visit)	100% of the allowed benefit after you pay a $15 Copay	70% of the allowed benefit after you meet the Annual Deductible
■ Physician's Office Services - Specialist (Copay is per visit)	100% of the allowed benefit after you pay a $30 Copay	70% of the allowed benefit after you meet the Annual Deductible
■ Outpatient services received at a Hospital or Alternate Facility See Section 6, *Additional Coverage Details*, for visit limits.	90% of the allowed benefit	70% of the allowed benefit after you meet the Annual Deductible
Kidney Resource Services (KRS)[2] See page 34 for explanation (These Benefits are for Covered Health Services provided through KRS only)	90% of the allowed benefit	Not Covered

Covered Health Services[1] See page 33 for explanation	Percentage of Eligible Expenses Payable by the Plan:	
	In-Network	**Out-of-Network**
Lab, X-Ray and Diagnostics - Outpatient	90% of the allowed benefit Lab and x-ray services related to asthma, diabetes, coronary artery disease, COPD, congestive heart failure, chronic low back pain, hyperlipidemia and hypertension are paid at 100% of the allowed benefit.	70% of the allowed benefit after you meet the Annual Deductible
Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	90% of the allowed benefit	70% of the allowed benefit after you meet the Annual Deductible
Medical Foods and Tube Feeding Supplies	90% of the allowed benefit	70% of the allowed benefit after you meet the Annual Deductible
Medical Supplies - Disposable See Section 6, *Additional Coverage Details* for limits.	90% of the allowed benefit	70% of the allowed benefit after you meet the Annual Deductible

Covered Health Services[1] See page 33 for explanation	Percentage of Eligible Expenses Payable by the Plan:	
	In-Network	**Out-of-Network**
Mental Health Services		
■ Hospital - Inpatient Stay	90% of the allowed benefit	70% of the allowed benefit after you meet the Annual Deductible
■ Outpatient Intensive Therapy	90% of the allowed benefit	70% of the allowed benefit after you meet the Annual Deductible
■ Physician's Office Services (Copay is per visit)	100% of the allowed benefit after you pay a $15 Copay	70% of the allowed benefit after you meet the Annual Deductible
Neurobiological Disorders - Autism Spectrum Disorder Services		
■ Hospital - Inpatient Stay	90% of the allowed benefit	70% of the allowed benefit after you meet the Annual Deductible
■ Outpatient Intensive Therapy	90% of the allowed benefit	70% of the allowed benefit after you meet the Annual Deductible
■ Physician's Office Services (Copay is per visit)	100% of the allowed benefit after you pay a $15 Copay	70% of the allowed benefit after you meet the Annual Deductible

Covered Health Services[1] See page 33 for explanation	Percentage of Eligible Expenses Payable by the Plan:	
	In-Network	**Out-of-Network**
Nutritional Counseling - Preventive		
■ Physician's Office Services - Primary Care Physician	100% of the allowed benefit	70% of the allowed benefit after you meet the Annual Deductible
■ Physician's Office Services - Specialist	100% of the allowed benefit	70% of the allowed benefit after you meet the Annual Deductible
Nutritional Counseling - Non-Preventive		
■ Physician's Office Services - Primary Care Physician (Copay is per visit)	100% of the allowed benefit after you pay a $15 Copay	70% of the allowed benefit after you meet the Annual Deductible
■ Physician's Office Services - Specialist (Copay is per visit)	100% of the allowed benefit after you pay a $30 Copay	70% of the allowed benefit after you meet the Annual Deductible
Obesity Surgery Out-of-Network Benefits include services provided at an In-Network facility that is not a Designated Facility and services provided at an Out-of-Network facility.	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 section.	
Ostomy Supplies	90% of the allowed benefit	70% of the allowed benefit after you meet the Annual Deductible
Pharmaceutical Products - Outpatient No physician's copay applies if no fee is assessed.	90% of the allowed benefit	70% of the allowed benefit after you meet the Annual Deductible
Physician Fees for Surgical and Medical Services	90% of the allowed benefit	70% of the allowed benefit after you meet the Annual Deductible

Covered Health Services[1] See page 33 for explanation	Percentage of Eligible Expenses Payable by the Plan:	
	In-Network	**Out-of-Network**
Physician's Office Services - Sickness and Injury		
■ Primary Care Physician (Copay is per visit)	100% of the allowed benefit after you pay a $15 Copay	70% of the allowed benefit after you meet the Annual Deductible
■ Specialist Physician (Copay is per visit) No physician's copay applies if no fee is assessed.	100% of the allowed benefit after you pay a $30 Copay	70% of the allowed benefit after you meet the Annual Deductible
Pregnancy – Maternity Services	Benefits will be the same as those stated under each Covered Health Service category in this section.	
Preventive Care Services		
■ Physician Office Services Including annual physical exams, well child, well woman and well man as described in Section 6, *Additional Coverage Details*.	100% of the allowed benefit	70% of the allowed benefit after you meet the Annual Deductible
■ Lab, X-ray or Other Preventive Tests Including mammography, colonoscopy, cervical cancer screening and prostate cancer screening as described Section 6, *Additional Coverage Details*.	100% of the allowed benefit	70% of the allowed benefit after you meet the Annual Deductible
■ Flu shots	100% of the allowed benefit	Not Covered
■ Immunizations	100% of the allowed benefit	70% of the allowed benefit after you meet the Annual Deductible
Private Duty Nursing - Outpatient	90% of the allowed benefit	70% of the allowed benefit after you meet the Annual Deductible

Covered Health Services[1] See page 33 for explanation	Percentage of Eligible Expenses Payable by the Plan:	
	In-Network	Out-of-Network
Prosthetic Devices	90% of the allowed benefit	70% of the allowed benefit after you meet the Annual Deductible
Reconstructive Procedures		
■ Physician's Office Services - Primary Care Physician (Copay is per visit)	100% of the allowed benefit after you pay a $15 Copay	70% of the allowed benefit after you meet the Annual Deductible
■ Physician's Office Services - Specialist (Copay is per visit)	100% of the allowed benefit after you pay a $30 Copay	70% after you meet the Annual Deductible
■ Hospital - Inpatient Stay	90% of the allowed benefit	70% of the allowed benefit after you meet the Annual Deductible
■ Physician Fees for Surgical and Medical Services	90% of the allowed benefit	70% of the allowed benefit after you meet the Annual Deductible
■ Prosthetic Devices	90% of the allowed benefit	70% of the allowed benefit after you meet the Annual Deductible
■ Surgery - Outpatient	90% of the allowed benefit	70% of the allowed benefit after you meet the Annual Deductible

Covered Health Services[1] See page 33 for explanation	Percentage of Eligible Expenses Payable by the Plan:	
	In-Network	**Out-of-Network**
Rehabilitation Services - Outpatient Therapy		
■ Occupational, Physical and Speech Therapy (Copay is per day not per therapy treatment)	100% of the allowed benefit after you pay a $30 Copay	70% of the allowed benefit after you meet the Annual Deductible
■ Cardiac and Pulmonary Rehabilitation Therapy See Section 6, *Additional Coverage Details*, for visit limits.	90% of the allowed benefit	70% of the allowed benefit after you meet the Annual Deductible
Scopic Procedures - Outpatient Diagnostic and Therapeutic	90% of the allowed benefit	70% of the allowed benefit after you meet the Annual Deductible
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services	90% of allowed benefit	70% of allowed benefit after you meet the Annual Deductible
■ Acute Inpatient Rehab See Section 6, *Additional Coverage Details*, for limits.	90% of allowed benefit	Not Covered
Substance Use Disorder Services		
■ Hospital - Inpatient Stay	90% of the allowed benefit	70% of the allowed benefit after you meet the Annual Deductible
■ Outpatient Intensive Therapy	90% of the allowed benefit	70% of the allowed benefit after you meet the Annual Deductible
■ Physician's Office Services (Copay is per visit)	100% of the allowed benefit after you pay a $15 Copay	70% of the allowed benefit after you meet the Annual Deductible

Covered Health Services[1] See page 33 for explanation	Percentage of Eligible Expenses Payable by the Plan:	
	In-Network	**Out-of-Network**
Surgery - Outpatient	90% of the allowed benefit	70% of the allowed benefit after you meet the Annual Deductible
Telemedicine Services	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 section.	
Temporomandibular Joint (TMJ) Services	Depending upon where the Covered Health Services is provided, Benefits for temporomandibular joint (TMJ) services will be the same as those stated under each Covered Health Services category in this section.	
Therapeutic Treatments - Outpatient	90% of the allowed benefit	70% of the allowed benefit after you meet the Annual Deductible
Transplantation Services Out-of-Network Benefits include services provided at an In-Network facility that is not a Designated Facility and services provided at an Out-of-Network facility.	Depending upon where the Covered Health Service is provided, Benefits for transplantation services will be the same as those stated under each Covered Health Service category in this section.	
Travel and Lodging (If services rendered by a Designated Facility)	For patient and companion(s) of patient undergoing transplant procedures.	
Treatment of Gender Dysphoria (Gender Identity Disorder)	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 section.	
Urgent Care Center Services (Copay is per visit)	100% of the allowed benefit after you pay a $30 Copay	70% of the allowed benefit after you meet the Annual Deductible

Covered Health Services[1] See page 33 for explanation	Percentage of Eligible Expenses Payable by the Plan:	
	In-Network	**Out-of-Network**
Virtual Visits Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.	100% of the allowed benefit after you pay a $15 Primary Care Physician Copay or a $30 Specialist Physician Copay	Out-of-Network Benefits are not available.
Vision Examinations ■ Medical health of the eye - Physician's Office Services - Primary Care Physician (Copay is per visit)	100% of the allowed benefit after a $15 Copay	70% of the allowed benefit after you meet the Annual Deductible
- Physician's Office Services - Specialist (Copay is per visit)	100% of the allowed benefit after a $30 Copay	70% of the allowed benefit after you meet the Annual Deductible
■ Routine refraction eye exam every calendar year. See Section 6, *Additional Coverage Details* for benefit maximums.	100% of the allowed benefit	70% of the allowed benefit after you meet the Annual Deductible
Vision Hardware	See Section 6, *Additional Coverage Details* for benefit maximums.	
Whole Blood and Blood Products	90% of the allowed benefit	70% of the allowed benefit after you meet the Deductible
Wigs	90% of the allowed benefit	70% of the allowed benefit after you meet the Annual Deductible

[1]You must obtain prior authorization from Care Coordination, as described in Section 4, *Care Coordination* to receive full Benefits before receiving certain Covered Health Services from an Out-of-Network provider. In general, if you visit an In-Network provider, that provider is responsible for obtaining prior authorization from Care Coordination before you receive certain Covered Health Services. See Section 6, *Additional Coverage Details* for further information.

[2]These Benefits are for Covered Health Services provided through CRS and KRS at a Designated Facility. For oncology services not provided through CRS, the Plan pays Benefits as described under *Physician's Office Services, Physician Fees for Surgical and Medical Services*, *Hospital - Inpatient Stay*, *Surgery - Outpatient*, *Scopic Procedures - Outpatient Diagnostic and Therapeutic* Lab, *X-Ray and Diagnostics – Outpatient*, and *Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine – Outpatient*.

SECTION 6 - ADDITIONAL COVERAGE DETAILS

What this section includes:
- Covered Health Services for which the Plan pays Benefits; and
- Covered Health Services that require you to obtain prior authorization before you receive them, and any reduction in Benefits that may apply if you do not call Care Coordination to obtain prior authorization.

This section supplements the second table in Section 5, *Plan Highlights*.

While the table provides you with Benefit limitations along with Copayment, Coinsurance and Annual Deductible information for each Covered Health Service, this section includes descriptions of the Benefits. These descriptions include any additional limitations that may apply, as well as Covered Health Services for which you must obtain prior authorization as required. The Covered Health Services in this section appear in the same order as they do in the table for easy reference. Services that are not covered are described in Section 8, *Exclusions*.

Acupuncture Services

The Plan pays for acupuncture services for chronic pain management provided that the service is performed in an office setting by a provider who is one of the following, either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body:

- Doctor of Medicine;
- Doctor of Osteopathy;
- Chiropractor; or
- Acupuncturist.

Covered Health Services include:

- all modalities performed by an Acupuncturist.

Coverage is not provided for chemotherapy nausea and vomiting, nausea of pregnancy, or postoperative dental pain.

Did you know…
You generally pay less out-of-pocket when you use an In-Network provider?

Allergy Care

Coverage includes skin testing, Physician services and injections. No copay applies if office visit not billed.

Ambulance Services (Medical Emergency and Non-Emergency)

The Plan covers Medical Emergency ambulance services and transportation provided by a licensed ambulance service to the nearest Hospital that offers Emergency Health Services. See Section 14, *Glossary* for the definition of Medical Emergency.

Ambulance service by air is covered in a Medical Emergency if ground transportation is impossible, or would put your life or health in serious jeopardy. If special circumstances exist, UnitedHealthcare may pay Benefits for Medical Emergency air transportation to a Hospital that is not the closest facility to provide Emergency Health Services.

The Plan also covers transportation provided by a licensed professional ambulance, other than air ambulance, (either ground or air ambulance, as UnitedHealthcare determines appropriate) between facilities when the transport is:

- from an Out-of-Network Hospital to an In-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; or
- from an acute facility to a sub-acute setting.

Prior Authorization Requirement
In most cases, the Claims Administrator will initiate and direct non-Emergency air transportation. If you are requesting non-Emergency air services, please remember that you must obtain prior authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Amino Acid-Based Elemental Formula

The Plan pays Benefits for amino acid-based elemental formula, regardless of delivery method, for the diagnosis and treatment of:

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

Cancer Resource Services (CRS)

The Plan pays Benefits for oncology services provided by Designated Facilities participating in the Cancer Resource Services (CRS) program. Designated Facility is defined in Section 14, *Glossary*.

For oncology services and supplies to be considered Covered Health Services, they must be provided to treat a condition that has a primary or suspected diagnosis relating to cancer. If you or a covered Dependent has cancer, you may:

- be referred to CRS by a Care Coordination Nurse;
- call CRS toll-free at (866) 936-6002; or
- visit www.myoptumhealthcomplexmedical.com.

To receive Benefits for a cancer-related treatment, you are not required to visit a Designated Facility. If you receive oncology services from a facility that is not a Designated Facility, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury;
- Physician Fees for Surgical and Medical Services;
- Scopic Procedures - Outpatient Diagnostic and Therapeutic;
- Therapeutic Treatments - Outpatient;
- Hospital - Inpatient Stay; and
- Surgery - Outpatient.

To receive Benefits under the CRS program, you must contact CRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CRS program if CRS provides the proper authorization to the Designated Facility provider performing the services (even if you self-refer to a provider in that In-Network).

Chiropractic Treatment

The Plan pays Benefits for chiropractic treatment when provided by a licensed chiropractor.

Cleft Lip/Palate

The Plan pays Benefits for orthodontic services, oral surgery and otologic, audiological and speech therapy/language for an enrolled Dependent child in connection with cleft lip or cleft palate or both. Services must be provided by or under the direction of a Physician.

Clinical Trials

Benefits are available for routine patient care costs incurred during participation in a qualifying clinical trial for the treatment of:

- cancer or other life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted;
- cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as UnitedHealthcare determines, a clinical trial meets the qualifying clinical trial criteria stated below;
- surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, for which, as UnitedHealthcare determines, a clinical trial meets the qualifying clinical trial criteria stated below; and
- other diseases or disorders which are not life threatening for which, as UnitedHealthcare determines, a clinical trial meets the qualifying clinical trial criteria stated below.

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

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

Routine patient care costs for qualifying clinical trials include:

- Covered Health Services for which Benefits are typically provided absent a clinical trial;
- Covered Health Services required solely for the provision of the investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
- Covered Health Services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

Routine costs for clinical trials do not include:

- the Experimental or Investigational Service or item. The only exceptions to this are:
  - certain Category B devices;
  - certain promising interventions for patients with terminal illnesses; and
  - other items and services that meet specified criteria in accordance with our medical and drug policies;
- items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;

- a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; and
- items and services provided by the research sponsors free of charge for any person enrolled in the trial.

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

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

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - *National Institutes of Health (NIH).* (Includes *National Cancer Institute (NCI)*);
  - *Centers for Disease Control and Prevention (CDC)*;
  - *Agency for Healthcare Research and Quality (AHRQ)*;
  - *Centers for Medicare and Medicaid Services (CMS)*;
  - a cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA)*;
  - a qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants; or
  - The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:

    - comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*; and
    - ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

- the study or investigation is conducted under an investigational new drug application reviewed by the *U.S. Food and Drug Administration*;
- the study or investigation is a drug trial that is exempt from having such an investigational new drug application;
- the clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (*IRBs*) before participants are enrolled in the trial. UnitedHealthcare may, at any time, request documentation about the trial; or

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

Prior Authorization Requirement
You must obtain prior authorization as soon as the possibility of participation in a Clinical Trial arises. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Congenital Heart Disease (CHD) Surgeries

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

UnitedHealthcare has specific guidelines regarding Benefits for CHD services. Contact United Resource Networks at (888) 936-7246 or Care Coordination at the toll-free number on your ID card for information about these guidelines.

Prior Authorization Requirements
For Out-of-Network Benefits you must obtain prior authorization as soon as the possibility of a CHD surgery arises. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

The Plan pays Benefits for Congenital Heart Disease (CHD) services ordered by a Physician and received at a CHD Resource Services program. Benefits include the facility charge and the charge for supplies and equipment. Benefits are available for the following CHD services:

- outpatient diagnostic testing;
- evaluation;
- surgical interventions;
- interventional cardiac catheterizations (insertion of a tubular device in the heart);
- fetal echocardiograms (examination, measurement and diagnosis of the heart using ultrasound technology); and
- approved fetal interventions.

CHD services other than those listed above are excluded from coverage, unless determined by United Resource Networks or the Claims Administrator to be proven procedures for the involved diagnoses. Contact United Resource Networks at (888) 936-7246 or Care Coordination at the toll-free number on your ID card for information about CHD services.

If you receive Congenital Heart Disease services from a facility that is not a Designated Facility, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury;
- Physician Fees for Surgical and Medical Services;
- Scopic Procedures - Outpatient Diagnostic and Therapeutic;
- Therapeutic Treatments - Outpatient;
- Hospital - Inpatient Stay; and
- Surgery - Outpatient.

Dental Services - Accident Only

Dental services are covered by the Plan when all of the following are true:

- treatment is necessary because of accidental damage;
- dental services are received from a Doctor of Dental Surgery or a Doctor of Medical Dentistry; and
- the dental damage is severe enough that initial contact with a Physician or dentist occurs 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.

The Plan also covers dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition limited to:

- dental services related to medical transplant procedures;
- initiation of immunosuppressives (medication used to reduce inflammation and suppress the immune system); and
- direct treatment of acute traumatic Injury, cancer or cleft palate.

Dental services for final treatment to repair the damage caused by accidental Injury must be started within 3 months of the accident unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care) and completed within 12 months of the accident.

The Plan pays for treatment of accidental Injury only for:

- 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; and
- replacement of lost teeth due to the Injury by implant, dentures or bridges.

State of Maryland offers dental coverage through United Concordia PPO 1-888-638-3384 & Delta Dental DHMO 1-844-697-0578.

Diabetes Services

The Plan pays Benefits for the Covered Health Services identified below.

Covered Diabetes Services	
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Benefits include outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. These services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals. Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes.

Covered Diabetes Services	
Diabetic Self-Management Items	Insulin pumps and supplies that are not fully implanted into the body, and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person including, but not limited to: ■ blood glucose monitors; ■ insulin syringes with needles, sterile, 1 cc or less; ■ blood glucose and urine test strips; ■ ketone test strips and tablets; ■ lancets and lancet devices; and ■ alcohol swabs and alcohol wipes. Insulin pumps and blood glucose monitors are subject to all the conditions of coverage stated under *Durable Medical Equipment* in this section. Benefits for diabetes equipment that meet the definition of Durable Medical Equipment are not subject to the limit stated under *Durable Medical Equipment* in this section. Diabetic test strips that work in conjunction with a glucometer are covered In-Network 100% of the allowed benefit and Out-of-Network 70% of the allowed benefit after you meet the Annual Deductible.

Prior Authorization Requirement
For Out-of-Network Benefits you must obtain prior authorization before obtaining any Durable Medical Equipment for the management and treatment of diabetes that exceeds $1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Durable Medical Equipment (DME)

The Plan pays for Durable Medical Equipment (DME) that is:

- ordered or provided by a Physician for outpatient use;
- used for medical purposes;
- not consumable or disposable;
- not of use to a person in the absence of a Sickness, Injury or disability;

- durable enough to withstand repeated use; and
- appropriate for use in the home.

If more than one piece of DME can meet your functional needs, you will receive Benefits only for the most Cost-Effective piece of equipment. Benefits are provided for a single unit of DME (example: one insulin pump) and for repairs of that unit. If you rent or purchase a piece of Durable Medical Equipment that exceeds this guideline, you may be responsible for any cost difference between the piece you rent or purchase and the piece UnitedHealthcare has determined is the most Cost-Effective.

Examples of DME include but are not limited to:

- equipment to administer oxygen;
- equipment to assist mobility, such as a standard wheelchair;
- Hospital beds;
- delivery pumps for tube feedings;
- negative pressure wound therapy pumps (wound vacuums);
- burn garments;
- insulin pumps, blood glucose monitors and all related necessary supplies as described under *Diabetes Services* in this section;
- external cochlear devices and implants. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure. See *Hospital - Inpatient Stay*, *Rehabilitation Services - Outpatient Therapy* and *Surgery - Outpatient* in this section;
- braces that stabilize an injured body part, 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;
- shoe orthotics and shoe inserts if ordered by a Physician and are custom made;
- equipment for the treatment of chronic or acute respiratory failure or conditions; and
- Breast pump and breast pump supplies.

The Plan also covers tubings, nasal cannulas, connectors and masks used in connection with DME.

Benefits also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required three-month rental period. Benefits are limited as stated below.

Note: DME is different from prosthetic devices – see *Prosthetic Devices* in this section.

Benefits for speech aid devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Plan.

Repairs, adjustments or replacements are subject to medical review. Benefits are provided for the repair/replacement of a type of Durable Medical Equipment if, upon review, the repair/replacement is deemed needed.

Shoe orthotics are covered and are limited to one pair per calendar year.

At UnitedHealthcare's discretion, replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price, or when a change in the Covered Person's medical condition occurs sooner than the three year timeframe. Repairs, including the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc., for necessary DME are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device. Requests for repairs may be made at any time and are not subject to the three year timeline for replacement.

Prior Authorization Requirements
For Out-of-Network Benefits you must obtain prior authorization before obtaining any Durable Medical Equipment that exceeds $1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Emergency Health Services - Outpatient

The Plan's Emergency services Benefit pays for outpatient treatment at a Hospital or Alternate Facility when required to stabilize a patient or initiate treatment.

If you are admitted as an inpatient to a Hospital directly from the Emergency room, you will not have to pay the Copay for Emergency Health Services. The Benefits for an Inpatient Stay in an In-Network Hospital will apply instead.

In-Network Benefits will be paid for an Emergency admission to an Out-of-Network Hospital as long as the Claims Administrator is notified within 48 hours of the admission or on the same day of admission if reasonably possible after you are admitted to an Out-of-Network Hospital. If you continue your stay in an Out-of-Network Hospital after the date your Physician determines that it is medically appropriate to transfer you to an In-Network Hospital, Out-of-Network Benefits will apply.

If criteria is not met for a Medical Emergency, the Plan coverage is 50% of the allowed benefit after a $150 Copay for the emergency room facility. This 50% penalty does not apply toward the Out-of-Pocket Maximum.

If a Primary Care Physician directs a Covered Person to the Emergency room, the Plan pays the claim regardless of the diagnosis.

The Plan pays Benefits for observation room charges as follows:

- Observation – up to 23 hours and 59 minutes – presented via Emergency Department
  - In-Network - 100% of the allowed benefit after you pay a $150 Copay per visit.
  - Out-of-Network - 70% of the allowed benefit after you meet the Annual Deductible.
- Observation – 24 hours or more presented via the Emergency Department
  - In-Network - 90% of the allowed benefit.
  - Out-of-Network - 70% of the allowed benefit after you meet the Annual Deductible.

Please remember for Out-of-Network Benefits, you must notify the Claims Administrator within 48 hours of the admission or on the same day of admission if reasonably possible if you are admitted to a Hospital as a result of a Medical Emergency.

Family Planning

Family planning services including examinations, insertion and removal of IUDs, Depo-Provera, Norplant, or prescriptions for birth control methods and, when medically appropriate, genetic counseling.

The Plan covers bilateral vasectomy and tubal ligation, in accordance with established medical practice.

Elective abortions performed within the first trimester of pregnancy are covered. Termination of Pregnancy for medical appropriateness, which is defined as documented fetal abnormalities and/or endangerment of the life of the mother if the pregnancy were completed, is covered.

Hearing Care and Hearing Aids

Benefits are available for the following Covered Health Services when received from a provider in the provider's office:

- routine hearing care screening as part of your preventative care;
- routine hearing exams up to one exam every 36 months;
- hearing exams in case of Injury or Sickness; and
- 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).

One hearing aid is covered for each impaired ear every 36 months.

The basic model hearing aid will not require prior authorization. If a member elects a hearing aid that is above the basic model, they will have to pay the difference of the basic model and the upgrade. For adults if device does not meet criteria for behind the ear, it will be denied.

Coverage is provided for hearing aids if the hearing aids are prescribed, fitted and dispensed by a licensed audiologist. For purposes 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 non-disposable.

A hearing aid consists of a microphone, amplifier and receiver. Benefits are available for a basic model hearing aid only that is purchased as a result of a written recommendation by a licensed audiologist. Benefits are provided for the basic model hearing aid and for charges for associated fitting and testing.

The Plan pay benefits for dispensing fees and assessments for hearing aids and hearing screenings.

Home Health Care

Covered Health Services include services received from a Home Health Agency that meet all of the following:

- 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;
- are provided in the Covered Person's home by a person licensed under the Health Occupations Article of the Maryland Code;
- ordered by a Physician;
- provided in your home by a registered nurse, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse;
- not considered Custodial Care, as defined in Section 14, *Glossary*; and
- provided on a part-time, Intermittent Care schedule when Skilled Care is required. Refer to Section 14, *Glossary* for the definition of Skilled Care.

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. The Plan 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 Deductible, Copayment or Coinsurance payments.
- 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 Deductible, Copayment or Coinsurance payments.

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.

The Claims Administrator will decide if Skilled Care is needed 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.

Any combination of In-Network Benefits and Out-of-Network Benefits is limited to 120 visits per calendar year. One visit equals four hours of Skilled Care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.

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

Hospice Care

Hospice care is an integrated program recommended by a Physician which provides comfort and support services for the terminally ill. Hospice care can be provided on an inpatient or outpatient basis and includes physical, psychological, social and spiritual and respite care for the terminally ill person, and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a Hospital.

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

Hospital - Inpatient Stay

Hospital Benefits are available for:

- non-Physician services and supplies received during an Inpatient Stay;
- room and board in a Semi-private Room (a room with two or more beds); and
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians.

The Plan will pay the difference in cost between a Semi-private Room and a private room only if a private room is necessary according to generally accepted medical practice.

Benefits for an Inpatient Stay in a Hospital are available only when the Inpatient Stay is necessary to prevent, diagnose or treat a Sickness or Injury. Benefits for other Hospital-based Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Benefits for Emergency admissions and admissions of less than 24 hours are described under *Emergency Health Services* and *Surgery - Outpatient, Scopic Procedures - Diagnostic and Therapeutic*, and *Therapeutic Treatments - Outpatient*, respectively.

Prior Authorization Requirement
Please remember for Out-of-Network Benefits for:

- a scheduled admission, you must obtain prior authorization five business days before admission;
- a non-elective admission (or admissions resulting from an Emergency) you must provide notification as soon as is reasonably possible.

If authorization is not obtained as required, or notification is not provided, Benefits will be reduced to 50% of Eligible Expenses.

Infertility Services

Benefits are available for the diagnosis and treatment of infertility including Medically Necessary, non-Experimental/Investigational artificial insemination/intrauterine insemination, in vitro fertilization and fertility drugs administered as a part of in vitro fertilization treatment as follows:

A. Covered Services:

1. Artificial Insemination and Intrauterine Insemination

a. Benefits are available when:

1) For a Member whose Spouse is of the opposite sex:

a) The Member and the Member's Spouse have a history of the inability to conceive after one (1) year of unprotected vaginal intercourse and the Member's Spouse's sperm is used; and,

b) The Member has had a fertility examination that resulted in a physician's recommendation advising artificial insemination or intrauterine insemination; and,

c) The Member's Spouse's sperm is used.

2) For a Member whose Spouse is of the same sex, the Member has had a fertility examination that resulted in a physician's recommendation advising artificial insemination or intrauterine insemination.

b. Benefits will not be provided for costs incurred by the Member in obtaining donor sperm/eggs.

2. In-Vitro Fertilization (IVF)

a. Benefits are available when:

1) For a Member whose Spouse is of the opposite sex, the oocytes (eggs) are physically produced by the Member and fertilized with sperm physically produced by the Member's Spouse.

2) The Member and the Member's Spouse have a history of involuntary infertility which may be demonstrated by a history of:

a) If the Member and the Member's Spouse are of the opposite sex, an inability to conceive after at least two

(2) years of unprotected vaginal intercourse failing to result in pregnancy; or

b) If the Member and the Member's Spouse are of the same sex, six (6) attempts of artificial insemination over the course of two (2) years failing to result in pregnancy; or

3) The infertility is associated with any of the following medical conditions:

a) Endometriosis;

b) Exposure in utero to diethylstilbestrol, commonly known as DES;

c) Blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy); or

d) Abnormal male factors, including oligospermia, contributing to the infertility.

4) The Member has been unable to attain a successful pregnancy through less costly infertility treatment for which coverage is available under this Agreement; and

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

3. For a Member whose Spouse is of the opposite sex, any charges associated with the collection of the Member's Spouse's sperm will not be covered unless the Spouse is also a Member. For a Member whose Spouse is of the same sex, benefits will not be provided for costs incurred by the Member in obtaining donor sperm.

In addition:

- The Plan pays Benefits for ovulation induction (excludes injectable medications, covered under the carved out pharmacy benefit plan).

- Insemination procedures: Artificial insemination (AI) and intra Uterine Insemination (IUI) limited to six (6) cycles per Covered Person's lifetime and must be done (when medically appropriate) before IVF attempts will be covered.

- Covered in vitro fertilization benefits are limited to three (3) in vitro fertilization attempts per live birth.

Kidney Resource Services (KRS)

The Plan pays Benefits for Comprehensive Kidney Solution (CKS) that covers both chronic kidney disease and End Stage Renal Disease (ESRD) disease provided by Designated Facilities participating in the Kidney Resource Services (KRS) program. Designated Facility is defined in Section 14, *Glossary*.

In order to receive Benefits under this program, KRS must provide the proper notification to the In-Network provider performing the services. This is true even if you self-refer to an In-Network provider participating in the program. Notification is required:

- prior to vascular access placement for dialysis; and
- prior to any ESRD services.

You or a covered Dependent may:

- be referred to KRS by Care Coordination; or
- call KRS toll-free at (866) 561-7518.

To receive Benefits related to ESRD and chronic kidney disease, you are not required to visit a Designated Facility. If you receive services from a facility that is not a Designated Facility, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury;
- Physician Fees for Surgical and Medical Services;
- Scopic Procedures - Outpatient Diagnostic and Therapeutic;
- Therapeutic Treatments - Outpatient;
- Hospital - Inpatient Stay; and
- Surgery - Outpatient.

To receive Benefits under the KRS program, you must contact KRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the KRS program if KRS provides the proper notification to the Designated Facility provider performing the services (even if you self-refer to a provider in that Network).

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; and
- mammography.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment; and
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*. Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services* in this section. CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient* in this section. Lab and x-ray services related to asthma, diabetes, coronary artery disease, COPD, congestive heart failure, chronic low back pain, hyperlipidemia and hypertension are paid In-Network 100% of the allowed benefit and Out-of-Network 70% of the allowed benefit after you meet the Annual Deductible.

Out-of-Network Office Based Lab and Diagnostic Processing:

New Processing applies to Lab and Diagnostic Services. Benefits for lab/diagnostic services will be based solely on the Network status of the lab/diagnostic provider, regardless of the Network status of the ordering physician. If a participating provider directs a member to a non-participating lab in error, the member may appeal to have the claim processed as In-Network.

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

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; and
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Medical Foods and Tube Feeding Supplies

Medical Foods are covered when determined to be the sole source of nutrition including amino acid-based elemental formula as described earlier in this section. Sole source means that the Employee is unable to tolerate (swallow or absorb) any other form of oral nutrition or that the nutrition is the Employee's primary source of sufficient caloric/nutrient intake to

achieve or maintain appropriate body weight. Medical foods may be obtained with a prescription (restricted, not over-the-counter) or without a prescription (over-the-counter).

Tube feeding supplies are provided for feeding pump and bag and tubing and related supplies for feeding when it is determined that the food product is the sole source of nutrition or for treatment of Inherited Metabolic Disease(s), unless otherwise noted in Section 8, *Exclusions*. Sole source means that the Employee is unable to tolerate (swallow or absorb) any other form of oral nutrition or that the nutrition is the Employee's primary source of sufficient caloric/nutrient intake to achieve or maintain appropriate body weight.

Medical Supplies - Disposable

The Plan pays Benefits for medical supplies and accessories which are necessary for the effective use of covered equipment (except those listed as exclusions in Section 8, *Exclusions*). The Plan covers the following medical supplies when skilled nursing is involved in wound care in the Covered Person's home setting:

- surgical dressing and burn garments for wound care;
- disposable supplies necessary for the effective use of covered DME items as described under *Durable Medical Equipment (DME)* earlier in this section including urinary catheters and urological supplies;
- supplies for renal dialysis equipment and machines; and
- compression stockings if they meet criteria are limited to two pair every 6 months which may be initially purchased for any Class I or higher garment, if prescribed by a physician, and with a CMN form describing symptoms and plan of care.

Mental Health Services

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

Benefits include the following services:

- Diagnostic evaluations and assessment;
- Treatment planning;
- Treatment and/or procedures;
- Referral services;
- Medication management;
- Individual, family, therapeutic group and provider-based case management services;
- Crisis intervention;
- Partial Hospitalization/Day Treatment;

- Services at a Residential Treatment Facility;
- Intensive Outpatient Treatment; and
- Biofeedback Therapy.

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

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

Special Mental Health Programs and Services

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Administrator may become available to you as part of your Mental Health Services Benefit. The Mental Health Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your Mental Illness which may not otherwise be covered under this Plan. You must be referred to such programs through the Mental Health/Substance Use Disorder Administrator, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such program or service is at the discretion of the Covered Person and is not mandatory.

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

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

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

Neurobiological Disorders - Autism Spectrum Disorder Services

The Plan pays Benefits for psychiatric services for Autism Spectrum Disorder (otherwise known as neurodevelopmental disorders) that are both of the following:

- Provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider; and
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning.

These Benefits describe only the psychiatric component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Service for which Benefits are available as described under the *Enhanced Autism Spectrum Disorder* benefit below.

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

- Diagnostic evaluations and assessment;
- Treatment planning;
- Treatment and/or procedures;
- Referral services;
- Medication management;
- Individual, family, therapeutic group and provider-based case management services;
- Crisis intervention;
- Partial Hospitalization/Day Treatment;
- Services at a Residential Treatment Facility;
- Intensive Outpatient Treatment; and
- Biofeedback Therapy.

Enhanced Autism Spectrum Disorder

Covered Health Services include enhanced Autism Spectrum Disorder services that are focused on educational/behavioral intervention that are habilitative in nature and that are backed by credible research demonstrating that the services or supplies have a measurable and beneficial effect on health outcomes. Benefits are provided for intensive behavioral therapies (educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning such as *Applied Behavioral Analysis (ABA)*).

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

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

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

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

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

Nutritional Counseling

The Plan will pay for Covered Health Services for medical education services provided in a Physician's office by an appropriately licensed or healthcare professional when:

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

Some examples of such medical conditions include, but are not limited to:

- coronary artery disease;
- congestive heart failure;
- severe obstructive airway disease;
- gout (a form of arthritis);
- renal failure;
- phenylketonuria (a genetic disorder diagnosed at infancy); and
- hyperlipidemia (excess of fatty substances in the blood).

When nutritional counseling services are billed as a preventive care service, these services will be paid as described under *Preventive Care Services* in this section.

Obesity Surgery

The Plan covers surgical treatment of obesity provided by or under the direction of a Physician when the treatment of morbid obesity 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 (NIH).

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 co-morbid medical condition including hypertension, a cardiopulmonary condition, sleep apnea or diabetes.

Benefits are available for obesity surgery services that meet the definition of a Covered Health Service, as defined in Section 14, *Glossary* and are not Experimental or Investigational or Unproven Services.

You will have access to a certain Network of Designated Facilities and Physicians participating in the Bariatric Resource Services (BRS) program, as defined in Section 14, *Glossary*, for obesity surgery services.

For obesity surgery services to be considered Covered Health Services under the BRS program, you must contact Bariatric Resource Services and speak with a nurse consultant prior to receiving services. You can contact Bariatric Resource Services by calling toll-free at (888) 936-7246.

If you receive obesity surgery services that are not performed as part of the Bariatric Resource Services program, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury;
- Physician Fees for Surgical and Medical Services;
- Scopic Procedures - Outpatient Diagnostic and Therapeutic;
- Therapeutic Treatments - Outpatient;
- Hospital - Inpatient Stay; and
- Surgery - Outpatient.

Assistant surgeon is covered at plan level benefits.

Prior Authorization Requirements
For Out-of-Network Benefits you must obtain prior authorization as soon as the possibility of obesity surgery arises. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

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

Ostomy Supplies

Benefits for ostomy supplies are limited to:

- pouches, face plates and belts;
- irrigation sleeves, bags and catheters; and
- skin barriers.

Pharmaceutical Products - Outpatient

The Plan pays for Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home. Examples of what would be included under this category are antibiotic injections in the Physician's office or inhaled medication in an Urgent Care Center for treatment of an asthma attack.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by UnitedHealthcare), 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.

Physician Fees for Surgical and Medical Services

The Plan pays Physician fees for surgical procedures and other medical care received from a Physician in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility, 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* in this section.

Physician's Office Services - Sickness and Injury

Benefits are paid by the Plan for Covered Health Services received in a Primary Care or Specialist Physician's office for the evaluation 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 genetic counseling. Benefits are available for Genetic Testing which is determined to be Medically Necessary following genetic counseling when ordered by the Physician and authorized in advance by UnitedHealthcare.

Benefits for preventive services are described under *Preventive Care Services* in this section.

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

An OB/GYN provider can be a Primary Care Physician. The Plan pays Benefits for an OB/GYN at the Primary Care Physician copay regardless of provider status.

The Plan pays Benefits for medical and surgical treatment of hyperhidrosis (excessive sweating. The Benefit is limited to Botox injections and surgical treatment.

Prior Authorization Requirements
Please remember for Out-of-Network Benefits, you must obtain prior authorization for Genetic Testing - BRCA. If authorization is not obtained as required, Benefits will be reduced to 50% of Eligible Expenses.

Please Note
Your Physician does not have a copy of your EOC, and is not responsible for knowing or communicating your Benefits.

Pregnancy - Maternity Services

Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications. Benefits include those of a certified nurse-midwife or pediatric nurse practitioner.

The Plan will pay Benefits for an Inpatient Stay of at least:

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

These are federally mandated requirements under the Newborns' and Mothers' Health Protection Act of 1996 which apply to this Plan. The Hospital or other provider is not required to get authorization for the time periods stated above. Authorizations are required for longer lengths of stay. If the mother agrees, the attending Physician may discharge the mother and/or the newborn child earlier than these minimum timeframes. In the event of such a shorter stay, the plan will provide coverage for at least one home care visit as described under *Home Health Care* in this section. 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 under *Home Health Care* in this section.

In addition, when a mother is required to remain hospitalized after childbirth for medical reasons and the mother requests that the newborn remain in the Hospital, the Plan will pay the cost of the additional hospitalization for the newborn for up to 4 days as required by state law.

Preventive care Benefits defined under the Health Resources and Services Administration (HRSA) requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Benefits for breast pumps also include the cost of purchasing one breast pump per Pregnancy in conjunction with childbirth. These Benefits are described under Section 5, *Plan Highlights*, under *Covered Health Services*.

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

- which pump is the most cost effective;
- whether the pump should be purchased or rented;
- duration of a rental;
- timing of an acquisition.

Benefits are only available if breast pumps are obtained from an In-Network DME provider. (No reimbursement if purchased retail and submitting receipt for reimbursement).

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.

No Copay applies for prenatal visits after the first visit.

Birthing centers are only covered if contracted as a health plan In-Network facility.

The Plan pays In-Network and Out-of-Network Benefits for breast feeding support and counseling.

The Plan pays Benefits for newborn circumcision.

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

Healthy moms and babies
The Plan provides a special prenatal program to help during Pregnancy. Participation is voluntary and free of charge. See Section 7, *Resources to Help you Stay Healthy*, for details.

Preventive Care Services

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

- evidence-based items or services 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; and
- with respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Covered Health Services for preventive care include:

Covered Preventive Care Services	
Well Child Care	■ child wellness services and related lab work are limited to thirteen (13) visits per child up to three (3) years of age and one (1) visit per year for ages three (3) through twenty-one (21); ■ office visits and related expenses for childhood and adolescent immunizations recommended by the *Advisory Committee on Immunization Practices of the Centers for Disease Control* (excluding immunizations for travel); ■ 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;

Covered Preventive Care Services	
	■ services for age-appropriate screening tests for tuberculosis, anemia, lead toxicity, hearing and vision as determined by the *Preventive Coverage Determination Guidelines*; ■ physical examinations, developmental assessments, parental anticipatory guidance and laboratory tests considered necessary by the Physician for services described above; ■ HPV injections for boys and girls; and ■ one flu shot per calendar year. (In-Network only).
Well Adult Care	■ adult Physical exams and related lab work are limited to one every calendar year for ages twenty-two (22) and older; ■ one flu shot per calendar year (In-Network only); and ■ shingles immunization.
Well Man	■ prostate cancer screening, including digital rectal exams and prostate-specific antigen (PSA) blood tests: - every 36 months for male Covered Persons who are between the ages of 40 and 75; - when used for the purpose of guiding patient management in monitoring the response to prostate cancer treatment; - 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. ■ screening colonoscopy or sigmoidoscopy and other colorectal cancer screening tests in accordance with the latest screening guidelines issued by the *American Cancer Society;* ■ an annual Chlamydia screening test for 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. "Chlamydia screening test" means any laboratory test that: ■ specifically detects for infection by one or more agents of Chlamydia trachomatis; and

Covered Preventive Care Services	
	■ is approved for this purpose by the *U.S. Food and Drug Administration*.
Well Woman	■ annual routine OB-GYN exam; ■ screening mammography include: - one mammogram per plan year for women 35 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; ■ 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; - 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; - 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; - you have hyperparathyroidism; or - you are being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy. ■ contraceptive methods and counseling – IUD's and tubal ligations; ■ breast pump and breast pump supplies (In-Network only); ■ counseling for sexually transmitted infections (In-Network only); ■ counseling and screening for human immune deficiency virus (HIV);

Covered Preventive Care Services	
	■ screening and counseling for interpersonal and domestic violence; ■ screening for gestational diabetes; ■ 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; ■ 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. "Multiple risk factors" means having a prior history of a sexually transmitted disease, new or multiple sex partners, inconsistent use of barrier contraceptives, or cervical ectopy. "Chlamydia screening test" means any laboratory test that: ■ specifically detects for infection by one or more agents of Chlamydia trachomatis; and ■ is approved for this purpose by the *U.S. Food and Drug Administration*. "Human Papillomavirus Screening Test" means any laboratory test that: ■ specifically detects for infection by one or more agents of the human papillomavirus; and ■ is approved for this purpose by the *U.S. Food and Drug Administration*.

The immunization benefit covers immunizations required for participation in school athletics and Lyme disease immunizations when medically necessary.

In addition to the services listed above, this preventive care benefit includes certain:

- routine lab tests;
- diagnostic consults to prevent disease and detect abnormalities;
- diagnostic radiology and nuclear imaging procedures to screen for abnormalities;
- breast cancer screening and genetic testing; and

- tests to support cardiovascular health.

These additional services are paid under the preventive care benefit when billed by your provider with a wellness diagnosis. Call the number on the back of your ID card for additional information regarding coverage available for specific services. The Plan pays Benefits for one flu shot per calendar year (In-Network only).

For questions about your preventive care Benefits under this Plan call the number on the back of your ID card.

Private Duty Nursing - Outpatient

The Plan covers Private Duty Nursing care given on an outpatient basis by a licensed nurse such as a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.).

Private duty nursing is nursing care that is provided to a patient on a one-to-one basis by licensed nurses in a 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; or
- the service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on a home-care basis, whether the service is skilled or non-skilled independent nursing.

Prosthetic Devices

Benefits are paid by the Plan for prosthetic devices and appliances that replace a limb or body part, or help an impaired limb or body part work. Examples include, but are not limited to:

- artificial arms, legs, feet and hands;
- artificial face, eyes, ears and nose; and
- breast prosthesis following mastectomy as required by the Women's Health and Cancer Rights Act of 1998, including 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 other than breast prostheses.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the most Cost-Effective prosthetic device that meets the minimum specifications for your needs. The device must be ordered or provided either by a Physician, or under a Physician's direction. If you purchase a prosthetic device that exceeds these minimum

specifications, the Plan may pay only the amount that would have paid for the prosthetic that meets the minimum specifications, and you may be responsible for paying any difference in cost.

Benefits are provided for the replacement of prosthetic device if, upon review, the replacement is deemed needed.

At UnitedHealthcare's discretion, prosthetic devices may be covered for damage beyond repair with normal wear and tear, when repair costs are less than the cost of replacement or when a change in the Covered Person's medical condition occurs sooner than the three year timeframe. Replacement of artificial limbs or any part of such devices may be covered when the condition of the device or part requires repairs that cost more than the cost of a replacement device or part.

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

Note: Prosthetic devices are different from DME - see *Durable Medical Equipment (DME)* in this section.

Reconstructive Procedures

Reconstructive Procedures are services performed when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function for an organ or body part. 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.

Improving or restoring physiologic function means that the organ or body part is made to work better. An example of a Reconstructive Procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored.

Benefits for Reconstructive Procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Replacement of an existing breast implant is covered by the Plan if the initial breast implant followed mastectomy. 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 UnitedHealthcare at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

Breast reduction is covered if determined to treat a physiological functional impairment or if coverage is required by the Women's Health and Cancer Rights Act of 1998.

There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. Cosmetic procedures are excluded from coverage. Procedures

that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. A good example is upper eyelid surgery. At times, this procedure will be done to improve vision, which is considered a Reconstructive Procedure. In other cases, improvement in appearance is the primary intended purpose, which is considered a Cosmetic Procedure. This Plan does not provide Benefits for Cosmetic Procedures, as defined in Section 14, *Glossary*.

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.

Assistant surgeon is covered at plan level benefits.

Prior Authorization Requirement
Please remember for Out-of-Network Benefits for:

- a scheduled admission, you must obtain prior authorization five business days before a scheduled reconstructive procedure is performed;
- a non-scheduled procedure (or inpatient admission resulting from an Emergency) you must provide notification within one business day or as soon as is reasonably possible.

If authorization is not obtained as required, or notification is not provided, Benefits will be reduced to 50% of Eligible Expenses.

Rehabilitation Services - Outpatient Therapy

The Plan provides short-term outpatient rehabilitation services (including habilitative services) for the following types of therapy:

- physical therapy;
- occupational therapy;
- speech therapy;
- post-cochlear implant aural therapy;
- pulmonary rehabilitation; and
- cardiac rehabilitation.

For all rehabilitation services, a licensed therapy provider, under the direction of a Physician, (when required by state law) must perform the services.

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

Habilitative Services

Benefits are provided for habilitative services provided for Covered Persons with a disabling condition when both of the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist, Physician, licensed nutritionist, licensed social worker or licensed psychologist.
- The initial or continued treatment must be proven and not Experimental or Investigational.

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and residential treatment are not habilitative services. A service that does not help the Covered Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service.

The Plan may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow the Plan to substantiate that initial or continued medical treatment is needed. When the treating provider anticipates that continued treatment is or will be required to permit the Covered Person to achieve demonstrable progress, the Plan may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

For purposes of this benefit, "habilitative services" means health care services that help a person keep, learn or improve skills and functioning for daily living.

Benefits for Durable Medical Equipment and prosthetic devices, when used as a component of habilitative services, are described under *Durable Medical Equipment* and *Prosthetic Devices* in this section.

Other than as described under Habilitative Services above, please note that the Plan 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. We will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.

Habilitative services for the treatment of a child with a congenital or genetic birth defect are covered for Dependent children under the age of 19 with no visit limits.

Benefits are limited to:

- 50 days per calendar year for physical, occupational and speech therapy combined;
- 20 visits per calendar year for pulmonary rehabilitation therapy; and

These limits apply to In-Network Benefits and Out-of-Network Benefits combined.

Unlimited visits for speech therapy for a diagnosis of brain injury, cardiac rehabilitation therapy and post-cochlear implant aural therapy.

"MD's" and "DO's" are providers for occupational, physical, and speech therapy services. Visits to either apply towards the day limits above.

Prior Authorization Requirements
For Out-of-Network Benefits you must obtain prior authorization five business days before receiving cardiac rehabilitation therapy, physical therapy, occupational therapy, and speech therapy or as soon as reasonably possible after:

- the sixth visit for physical therapy;
- the sixth visit for occupational therapy; and
- the first visit for speech therapy.

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

Scopic Procedures - Outpatient Diagnostic and Therapeutic

The Plan pays for 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.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment; and
- Physician services for anesthesiologists, pathologists and radiologists.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

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.

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

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Facility services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility are covered by the Plan. Benefits include:

- non-Physician services and supplies received during the Inpatient Stay;
- room and board in a Semi-private Room (a room with two or more beds); and
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits are available when skilled nursing and/or Inpatient Rehabilitation Facility services are needed on a daily basis. Benefits are also available in a Skilled Nursing Facility or Inpatient Rehabilitation Facility for treatment of a Sickness or Injury that would have otherwise required an Inpatient Stay in a Hospital.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

UnitedHealthcare 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 are available only 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; and
- you will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when:

- it is delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient;
- it is ordered by a Physician;
- it is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair; and
- it requires clinical training in order to be delivered safely and effectively.

You are expected to improve to a predictable level of recovery. 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.

Note: The Plan does not pay Benefits for Custodial Care or Domiciliary Care, even if ordered by a Physician, as defined in Section 14, *Glossary*.

Any combination of In-Network Benefits and Out-of-Network Benefits is limited to 180 days per calendar year.

Days beyond the 180 day calendar year limit may be granted based on additional medical information.

Prior Authorization Requirement
Please remember for Out-of-Network Benefits for:

- a scheduled admission, you must obtain prior authorization five business days before admission;
- a non-elective admission (or admission resulting from an Emergency) you must provide notification as soon as is reasonably possible.

If authorization is not obtained as required, or notification is not provided, Benefits will be reduced to 50% of Eligible Expenses.

Substance Use Disorder Services

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

Benefits include the following services:

- Diagnostic evaluations and assessment;
- Treatment planning;
- Treatment and/or procedures;
- Referral services;
- Medication management;
- Individual, family, therapeutic group and provider-based case management;
- Crisis intervention;
- Partial Hospitalization/Day Treatment;
- Services at a Residential Treatment Facility;
- Intensive Outpatient Treatment; and
- Methadone Treatment.

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

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

Special Substance Use Disorder Programs and Services

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Administrator may become available to you as part of your Substance Use Disorder Services Benefit. The Substance Use Disorder Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your substance use disorder which may not otherwise be covered under this Plan. You must be referred to such programs through the Mental Health/Substance Use Disorder Administrator, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such program or service is at the discretion of the Covered Person and is not mandatory.

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

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

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

Surgery - Outpatient

The Plan pays for 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:

- the facility charge and the charge for supplies and equipment;
- certain surgical scopic procedures (examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy); and
- Physician services for radiologists, anesthesiologists and pathologists. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Assistant surgeon is covered at plan level benefits.

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

Telemedicine Services

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

Telemedicine does not include:

- an audio-only telephone conversation between a health care provider and a patient;
- an electronic mail message between a health care provider and a patient; or
- a facsimile transmission between a health care provider and a patient.

Temporomandibular Joint (TMJ) Services

The Plan covers diagnostic and surgical and non-surgical treatment of conditions affecting the temporomandibular joint when provided by or under the direction of a Physician. Coverage includes necessary treatment required as a result of accident, trauma, a Congenital Anomaly, developmental defect, or pathology.

Diagnostic treatment includes examination, radiographs and applicable imaging studies and consultation. Non-surgical treatment includes clinical examinations, oral appliances (orthotic splints), arthrocentesis and trigger-point injections.

Benefits are provided for surgical treatment if:

- there is clearly demonstrated radiographic evidence of significant joint abnormality;
- non-surgical treatment has failed to adequately resolve the symptoms; and
- pain or dysfunction is moderate or severe.

Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy, open or closed reduction of dislocations and TMJ implants.

Benefits for an Inpatient Stay in a Hospital and Hospital-based Physician services are described in this section under *Hospital – Inpatient Stay* and *Physician Fees for Surgical and Medical Services*, respectively.

Please note that Benefits are not available for charges for services that are dental in nature.

State of Maryland offers dental coverage through United Concordia PPO 1-888-638-3384 & Delta Dental DHMO 1-844-697-0578.

Prior Authorization Requirement
For Out-of-Network Benefits you must obtain prior authorization five business days before temporomandibular joint services are performed. If you fail to obtain prior authorization, Benefits will be reduced to 50% of Eligible Expenses.

Therapeutic Treatments - Outpatient

The Plan pays Benefits for 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:

- education is required for a disease in which patient self-management is an important component of treatment; and
- 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; and
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

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

Transplantation Services

Inpatient facility services (including evaluation for transplant, organ procurement and donor searches) for transplantation procedures must be ordered by a provider. Benefits are available to the donor and the recipient when the recipient is covered under this Plan. The transplant must meet the definition of a Covered Health Service and cannot be Experimental or Investigational, or Unproven. Examples of transplants for which Benefits are available include but are not limited to:

- bone marrow (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service;

- heart;
- heart/lung;
- kidney;
- kidney/pancreas;
- liver;
- liver/kidney;
- liver/intestinal;
- lung/lobar lung;
- multi-visceral;
- pancreas;
- small bowel; and
- small bowel/liver.

Benefits are also available for cornea transplants. You are not required to obtain prior authorization from United Resource Networks or Care Coordination of a cornea transplant nor is the cornea transplant required to be performed at a Designated Facility.

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 Plan.

The Plan has specific guidelines regarding Benefits for transplant services. Contact United Resource Networks at (888) 936-7246 or Care Coordination at the telephone number on your ID card for information about these guidelines.

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

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

Travel and Lodging

United Resource Networks or Care Coordination will assist the patient and family with travel and lodging arrangements related to:

- transplantation services.

For travel and lodging services to be covered, the patient must be receiving services at a Designated Facility through United Resource Networks.

The Plan covers expenses for travel and lodging for the patient, provided he or she is not covered by Medicare, and a companion as follows:

- transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the transplant for the purposes of an evaluation, the procedure or necessary post-discharge follow-up;
- Eligible Expenses for lodging for the patient (while not a Hospital inpatient) and one companion; or
- if the patient is an enrolled Dependent minor child, the transportation expenses of two companions will be covered.

Travel and lodging expenses are only available if the recipient lives more than 50 miles from the Designated Facility. UnitedHealthcare must receive valid receipts for such charges before you will be reimbursed. Examples of travel expenses may include:

- airfare at coach rate;
- taxi or ground transportation; or
- mileage reimbursement at the IRS rate for the most direct route between the patient's home and the Designated Facility.

A maximum of 60 days per transplant, per Covered Person applies for all travel and lodging expenses reimbursed under this Plan in connection with all transplant procedures.

Support in the event of serious illness
If you or a covered family member has cancer or needs an organ or bone marrow transplant, UnitedHealthcare can put you in touch with quality treatment centers around the country.

Treatment of Gender Dysphoria (Gender Identity Disorder)

The Plan pays Benefits for the treatment of gender dysphoria (Gender Identity Disorder) as described under non-surgical or surgical treatment for gender dysphoria.

Non-Surgical Treatment of Gender Dysphoria:

The Plan covers non-surgical treatment for gender dysphoria; the following non-surgical treatments are covered:

- **Outpatient psychotherapy/mental health services** for gender dysphoria and associated co-morbid psychiatric diagnoses. The benefits are the same as any other outpatient mental health service in the Program.

- **Continuous hormone replacement therapy**. The benefits are the same as any other eligible drug in the Program. Note the following clarifications:

  - Hormones injected by a medical provider (for example during an office visit) are covered by the medical plan. Benefits for these injections vary depending on the plan design.
  - Oral and self-injected hormones from a pharmacy are not covered under the medical plan. Refer to the Benefit Guide for specific prescription drug product coverage and exclusion terms. They are covered under the separately provided prescription drug plan, if enrolled.

- **Outpatient laboratory testing** to monitor continuous hormone therapy. The benefits are the same as any other outpatient diagnostic service in the Program.

Surgical Treatment of Gender Dysphoria:

The Plan covers surgical treatment for gender dysphoria; the following are covered when the eligibility qualifications for surgery are met below:

- **Gender reassignment surgery.** Medically necessary gender reassignment procedures are covered, as follows. The procedures identified in this paragraph and any combination of procedures within each type of transition – *male-to-female transition*: orchiectomy, penectomy, clitoroplasty, labiaplasty, vaginoplasty, thyroid chondroplasty; *female-to-male transition:* vaginectomy, hysterectomy, mastectomy, salpingo-oophorectomy, ovariectomy, metoidioplasty, phalloplasty, scrotoplasty, placement of testicular prostheses; *either:* urethroplasty – are considered medically necessary for treatment of gender dysphoria when *all* of the following criteria are met:

  - The individual is at least 18 years of age; and
  - The individual has capacity to make fully informed decisions and consent for treatment; and
  - The individual has been diagnosed with gender dysphoria and exhibits all of the following:

    - The desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatment; and
    - The gender dysphoria (pre and post diagnosis) has been present persistently for at least two years; and
    - The gender dysphoria is not a symptom of another mental disorder; and
    - The gender dysphoria causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

- For individuals without a medical contraindication or not otherwise unable to take hormones, the individual has undergone a minimum of 12 months of continuous hormonal therapy when recommended by a mental health professional and provided under the supervision of a physician. (Hormonal therapy is not required as a prerequisite to a mastectomy.); and
- Documentation that the individual has completed a minimum of 12 months of successful continuous, substantially full time real-life experience in their new gender, across a wide range of life experiences and events that may occur throughout the year. (The real-life experience is not required as a perquisite to a mastectomy, augmentation mammoplasty, thyroid chondroplasty, hysterectomy, salpingo-oophorectomy, or orchiectomy.); and
- Regular participation in psychotherapy and/or ongoing clinical treatment throughout the real-life experience may be required when recommended by a treating medical or behavioral health practitioner or when medically necessary; and
- If the individual has significant medical or mental health issues present, they must be reasonably well controlled. If the individual is diagnosed with severe psychiatric disorders and impaired reality testing (e.g., psychotic episodes, bipolar disorder, dissociative identity disorder, borderline personality disorder), an effort must be made to improve these conditions with psychotropic medications and/or psychotherapy before surgery is contemplated; and
- *****Two referrals from qualified mental health professionals who have independently assessed the individual. If the first referral is from the individual's psychotherapist, the second referral should be from a person who has only had an evaluative role with the individual. Two separate letters, or one letter signed by both (e.g., if practicing within the same clinic) are required.

*****At least one of the professionals submitting a letter must have a doctoral degree (Ph.D., M.D., Ed.D., D.Sc., D.S.W., or Psy.D) and be capable of adequately evaluating co-morbid psychiatric conditions. One letter is sufficient if signed by two providers, one of whom has met the doctoral degree specifications, in addition to the specifications set forth above. One letter signed by an appropriate provider is sufficient to support benefits for a mastectomy. The medical documentation should include the start date of living full time in the new gender, when applicable.

- **Augmentation mammoplasty.** Provided the criteria above for gender reassignment surgery have been satisfied, augmentation mammoplasty (including breast prosthesis if necessary) may be covered for male-to-female transgender individuals if the Physician prescribing hormones and the treating surgeon have documented that, after undergoing hormone treatment for 12 months, breast size continues to cause clinically significant distress in social, occupational, or other areas of functioning.

Note on gender specific services for post-transition transgender persons

Gender-specific services may be medically necessary for transgender persons appropriate to their anatomy. Examples include:

- Breast cancer screening may be medically necessary for female to male transgender persons who have not undergone a mastectomy;
- Prostate cancer screening may be medically necessary for male to female transgender individuals who have retained their prostate.

Notes:

For individuals considering hysterectomy/salpingo-oophorectomy, orchiectomy, vaginectomy or vaginoplasty procedures a total of 12 months of continuous hormonal sex reassignment is required.

Cryopreservation, storage, and thawing of reproductive tissue (i.e., oocytes, ovaries, testicular tissue) and the charged associated therewith (e.g., office, hospital, ultrasounds, laboratory tests, etc.) are not covered.

Urgent Care Center Services

The Plan provides Benefits for services, including professional services, received at an Urgent Care Center, as defined in Section 14, *Glossary*. When Urgent Care services are provided in a Physician's office, the Plan pays Benefits as described under *Physician's Office Services - Sickness and Injury* earlier in this section.

Virtual Visits

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

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

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

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

Vision Examinations and Vision Hardware

The Plan pays Benefits for:

- vision screenings, which could be performed as part of an annual physical examination in a provider's office (vision screenings do not include refractive examinations to detect vision impairment);
- one routine vision exam, including refraction, to detect vision impairment by a provider in the provider's office every calendar year. The Plan's allowed benefit pays up to $45 for a routine eye refraction exam; and
- vision hardware (frames, lenses, contacts).

Adult Vision

- Vision Exam (Medical health of the eye)
  - In-Network - $15 copay PCP or $30 copay specialist.
  - Out-of-Network - 70% of the allowed benefit after the deductible.
- Vision Exam (Routine with refraction)
  - In-Network -100% of the allowed benefits with $45 benefit limit.
  - Out-of-Network - 70% of the allowed benefit after the deductible with $45 benefit limit.
- Lenses (per pair) are covered up to one per year as follows:
  In or Out-of-Network
  - single vision lenses up to $52;
  - bifocal lenses up to $82;
  - trifocal lenses up to $101; or
  - lenticular lenses up to $181.
- Frames are covered once per year (in lieu of contact lenses) up to $45.
  In or Out-of-Network
- Contact lenses are covered once per year (in lieu of frames/lenses) as follows:
  In or Out-of-Network
  - Contact lenses up to $97; or
  - Medically necessary contact lenses up to $285; or
  - Aphakic lenses payable at $54, glass $154, plastic $126 and aspheric $162.

Pediatric Vision (Dependent children age 18 and under)

- Vision Exam (Medical)
  - In-Network - $15 copay PCP or $30 copay specialist.
  - Out-of-Network - 70% of the allowed benefit after the deductible.
- Vision Exam (Routine)
  - In-Network -100% of the allowed benefits.
  - Out-of-Network - 70% of the allowed benefit after the deductible.

Vision hardware (frames, lenses, contacts) are covered In and Out-of-Network

- Frames (one per plan year) – Covers up to $70. If you choose to get high end frames you can be billed for the amount above the allowed amount as that would be considered cosmetic versus medically necessary.
- Basic Prescription Lenses - Coverage is 100% of the billed charges.
- Contact lenses (in lieu of frames and lenses) - Coverage is 100% of the billed charges (2 refills per year which is a total of 3 when the first is based on first set at appointment).

* Basic Lenses means spectacle lenses with no "add-ons" such as glare resistant treatment, ultraviolet coating, progressive lenses, transitional lenses, etc.

Vision benefit is a reimbursement benefit for routine exams and hardware. Claim must be filed. Benefits under this section also include medical eye examinations (dilated retinal examinations) for Covered Persons with related medical health of the eye.

State of Maryland offers discounted services on laser vision correction surgery through Laser Vision Network of America.

Whole Blood and Blood Products

The Plan pays Benefits for whole blood products, blood products, derivatives and components, artificial blood products, biological serum and the administration of the agent. Blood products shall include any product which is created from a component of blood such as, but not limited to plasma, packed red blood cells, platelets, albumin, Factor VIII, immunoglobulin and prolastin.

Wigs

The Plan pays Benefits for wigs and other scalp hair prosthesis only for loss of hair resulting from chemotherapy or radiation therapy for cancer.

SECTION 7 - RESOURCES TO HELP YOU STAY HEALTHY

What this section includes:
Health and well-being resources available to you, including:

- State of Maryland Wellness Program;
- Consumer Solutions and Self-Service Tools;
- Disease and Condition Management Services; and
- Wellness Programs.

State of Maryland believes in giving you the tools you need to be an educated health care consumer. To that end, State of Maryland has made available several convenient educational and support services, accessible by phone and the Internet, which can help you to:

- take care of yourself and your family members;
- manage a chronic health condition; and
- navigate the complexities of the health care system.

NOTE:
Information obtained through the services identified in this section is based on current medical literature and on Physician review. It is not intended to replace the advice of a doctor. The information is intended to help you make better health care decisions and take a greater responsibility for your own health. UnitedHealthcare and State of Maryland are not responsible for the results of your decisions from the use of the information, including, but not limited to, your choosing to seek or not to seek professional medical care, or your choosing or not choosing specific treatment based on the text.

State of Maryland Wellness Program

The State of Maryland Wellness Program will require employees, non-Medicare eligible retirees and enrolled spouses (children are not eligible to participate, regardless of age) to complete healthy activities throughout the calendar year. Once these activities are completed, enrollees will enjoy enhanced benefits such as waiving copays for all Primary Care Physician (PCP) visits.

IMPORTANT
If it is unreasonably difficult due to a medical condition for you to achieve the standards for the reward under State of Maryland Wellness Program, or if it is medically inadvisable for you and your Spouse to attempt to achieve the standards for the reward under this program, contact the Employee Benefits Division regarding alternate activities or to provide documentation to waive certain criteria.

Registering on www.myuhc.com Portal
You are already enrolled in the State of Maryland Wellness Program by being enrolled in this Plan. However, in order to benefit from the State of Maryland Wellness Program you must be registered on the **www.myuhc.com** portal. Simply go to **www.myuhc.com** and follow the directions on the website to register.

Participation is without extra charge. If you would like additional information regarding the program, please visit **www.myuhc.com** or call the toll-free number on the back of your ID card.

SEE SECTION 3 - HOW THE PLAN WORKS - FOR COMPLETE DETAILS ON THE STATE OF MARYLAND WELLNESS PROGRAM.

Weight Loss Program Reimbursement All enrolled employees, retirees and covered spouses (children are not eligible to participate, regardless of age).	Payable at 100% up to an annual maximum of $150 per enrolled employee, retiree or covered spouse. Qualifying weight loss programs include all weight loss programs on-site and/or online. Excludes: - Fees paid for food, books, videos, scales, or other items not included as part of the fee for the course or class; - penalties of fees; and - credit card receipts are not acceptable.

How to File Your Fitness/Weight Loss Reimbursement Claim

You and/or your covered dependents are eligible to receive reimbursement for the weight loss benefit provided it meets the plan requirements. To request reimbursement, complete a UHC Weight Loss Reimbursement form available on uhcmaryland.com and mail it with the required documentation to the address noted on the form. Please note that the required documentation must be an actual receipt from the program and that credit card receipts are not accepted.

Consumer Solutions and Self-Service Tools

Health Assessment

You and your Spouse are invited to learn more about your health and wellness at **www.myuhc.com** and are encouraged to participate in the online health . The health assessment is an interactive questionnaire designed to help you identify your healthy habits as well as potential health risks.

Your health assessment is kept confidential. Completing the assessment will not impact your Benefits or eligibility for Benefits in any way.

To find the health assessment, log in to **www.myuhc.com**. After logging in, access your personalized *Health & Wellness* page. If you need any assistance with the online assessment, please call the number on the back of your ID card.

Health Improvement Plan

You can start a Health Improvement Plan at any time. This plan is created just for you and includes information and interactive tools, plus online health coaching recommendations based on your profile.

Online coaching is available for:

- nutrition;
- exercise;
- weight management;
- stress;
- smoking cessation;
- diabetes; and
- heart health.

To help keep you on track with your Health Improvement Plan and online coaching, you'll also receive personalized messages and reminders - State of Maryland's way of helping you meet your health and wellness goals.

NurseLine℠

NurseLine℠ is a toll-free telephone service that puts you in immediate contact with an experienced registered nurse any time, 24 hours a day, seven days a week. Nurses can provide health information for routine or urgent health concerns. When you call, a registered nurse may refer you to any additional resources that State of Maryland has available to help you improve your health and well-being or manage a chronic condition. Call any time when you want to learn more about:

- a recent diagnosis;
- a minor Sickness or Injury;
- men's, women's, and children's wellness;
- how to take prescription drugs safely;
- self-care tips and treatment options;
- healthy living habits; or
- any other health related topic.

NurseLine[SM] gives you another convenient way to access health information. By calling the same toll-free number, you can listen to one of the Health Information Library's over 1,100 recorded messages, with over half in Spanish.

NurseLine[SM] is available to you at no cost. To use this convenient service, simply call the toll-free number on the back of your ID card.

Note: If you have a Medical Emergency, call 911 instead of calling NurseLine[SM].

Your child is running a fever and it's 1:00 AM. What do you do?
Call NurseLine[SM] toll-free, any time, 24 hours a day, seven days a week. You can count on NurseLine[SM] to help answer your health questions.

With NurseLine[SM], you also have access to nurses online. To use this service, log onto **www.myuhc.com** and click "Live Nurse Chat" in the top menu bar. You'll instantly be connected with a registered nurse who can answer your general health questions any time, 24 hours a day, seven days a week. You can also request an e-mailed transcript of the conversation to use as a reference.

Note: If you have a Medical Emergency, call 911 instead of logging onto **www.myuhc.com**.

Treatment Decision Support

In order to help you make informed decisions about your health care, UnitedHealthcare has a program called Treatment Decision Support. This program targets specific conditions as well as the treatments and procedures for those conditions.

This program offers:

- access to accurate, objective and relevant health care information;
- coaching by a nurse through decisions in your treatment and care;
- expectations of treatment; and
- information on high quality providers and programs.

Conditions for which this program is available include:

- back pain;
- knee & hip replacement;
- prostate disease;
- prostate cancer;
- benign uterine conditions;
- breast cancer;

- coronary disease and
- bariatric surgery.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on the back of your ID card.

UnitedHealth Premium℠ Program

UnitedHealthcare designates Network Physicians and facilities as UnitedHealth Premium℠ Program Physicians or facilities for certain medical conditions. Physicians and facilities are evaluated on two levels - quality and efficiency of care. The UnitedHealth Premium℠ Program was designed to:

- help you make informed decisions on where to receive care;
- provide you with decision support resources; and
- give you access to Physicians and facilities across areas of medicine that have met UnitedHealthcare's quality and efficiency criteria.

For details on the UnitedHealth Premium℠ Program including how to locate a UnitedHealth Premium℠ Physician or facility, log onto **www.myuhc.com** or call the toll-free number on your ID card.

www.myuhc.com

UnitedHealthcare's member website, **www.myuhc.com**, provides information at your fingertips anywhere and anytime you have access to the Internet. **www.myuhc.com** opens the door to a wealth of health information and convenient self-service tools to meet your needs.

With **www.myuhc.com** you can:

- receive personalized messages that are posted to your own website;
- research a health condition and treatment options to get ready for a discussion with your Physician;
- search for In-Network providers available in your Plan through the online provider directory;
- access all of the content and wellness topics from NurseLine℠ including Live Nurse Chat 24 hours a day, seven days a week;
- complete a health risk assessment to identify health habits you can improve, learn about healthy lifestyle techniques and access health improvement resources;
- use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area; and

- use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

Registering on www.myuhc.com
If you have not already registered as a **www.myuhc.com** subscriber, simply go to **www.myuhc.com** and click on "Register Now." Have your UnitedHealthcare ID card handy. The enrollment process is quick and easy.

Visit **www.myuhc.com** and:

- make real-time inquiries into the status and history of your claims;
- view eligibility and Plan Benefit information, including Copays and Annual Deductibles;
- view and print all of your Explanation of Benefits (EOBs) online; and
- order a new or replacement ID card or, print a temporary ID card.

Want to learn more about a condition or treatment?
Log on to **www.myuhc.com** and research health topics that are of interest to you. Learn about a specific condition, what the symptoms are, how it is diagnosed, how common it is, and what to ask your Physician.

Disease and Condition Management Services

Disease Management Services

If you have been diagnosed with or are at risk for developing certain chronic medical conditions you may be eligible to participate in a disease management program at no cost to you. The heart failure, coronary artery disease, diabetes, asthma and COPD programs are designed to support you. This means that you will receive free educational information through the mail, and may even be called by a registered nurse who is a specialist in your specific medical condition. This nurse will be a resource to advise and help you manage your condition.

These programs offer:

- educational materials mailed to your home that provide guidance on managing your specific chronic medical condition. This may include information on symptoms, warning signs, self-management techniques, recommended exams and medications;
- access to educational and self-management resources on a consumer website;
- an opportunity for the disease management nurse to work with your Physician to ensure that you are receiving the appropriate care; and
- toll-free access to and one-on-one support from a registered nurse who specializes in your condition. Examples of support topics include:
  - education about the specific disease and condition,
  - medication management and compliance,
  - reinforcement of on-line behavior modification program goals,

- preparation and support for upcoming Physician visits,
- review of psychosocial services and community resources,
- caregiver status and in-home safety,
- use of mail-order pharmacy and In-Network providers.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on the back of your ID card.

HealtheNotes℠

UnitedHealthcare provides a service called HealtheNotes to help educate members and make suggestions regarding your medical care. HealtheNotes provides you and your Physician with suggestions regarding preventive care, testing or medications, potential interactions with medications you have been prescribed, and certain treatments. In addition, your HealtheNotes report may include health tips and other wellness information.

UnitedHealthcare makes these suggestions through a software program that provides retrospective, claims-based identification of medical care. Through this process patients are identified whose care may benefit from suggestions using the established standards of evidence based medicine as described in Section 14, *Glossary* under the definition of Covered Health Services.

If your Physician identifies any concerns after reviewing his or her HealtheNotes report, he or she may contact you if he or she believes it to be appropriate. In addition, you may use the information in your report to engage your Physician in discussions regarding your health and the identified suggestions. Any decisions regarding your care, though, are always between you and your Physician.

If you have questions or would like additional information about this service, please call the number on the back of your ID card.

Health Programs

Real Appeal Program (Effective March 1, 2016)

UnitedHealthcare provides the Real Appeal program, which represents a practical solution for weight related conditions, with the goal of helping people at risk from obesity-related diseases and those who want to maintain a healthy lifestyle. This program is designed to support individuals over the age of 18. This intensive, multi-component behavioral intervention provides a 52-week virtual approach that includes one-on-one coaching and online group participation with supporting video content, delivered by a live virtual coach. The experience will be personalized for each individual through an introductory call.

This program will be individualized and may include, but is not limited to, the following:

- Online support and self-help tools: Personal one-on-one coaching, group support sessions, including integrated telephonic support, and mobile applications.

- Education and training materials focused on goal setting, problem-solving skills, barriers and strategies to maintain changes.
- Behavioral change guidance and counseling by a specially trained health coach for clinical weight loss.

Participation is completely voluntary and without any additional charge or cost share. There are no Copays, Coinsurance, or Deductibles that need to be met when services are received as part of the Real Appeal program. If you would like to participate, or if you would like any additional information regarding the program, please call Real Appeal at 1-844-344-REAL (1-844-344-7325). TTY users can dial 711 or visit **www.realappeal.com**.

Healthy Pregnancy Program

If you are pregnant and enrolled in the medical Plan, you can get valuable educational information and advice by calling the toll-free number on your ID card. This program offers:

- pregnancy consultation to identify special needs;
- written and on-line educational materials and resources;
- 24-hour toll-free access to experienced maternity nurses;
- a phone call from a care coordinator during your Pregnancy, to see how things are going; and
- a phone call from a care coordinator approximately four weeks postpartum to give you information on infant care, feeding, nutrition, immunizations and more.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first 12 weeks of Pregnancy. You can enroll any time, up to your 34th week. To enroll, call the toll-free number on the back of your ID card.

As a program participant, you can call any time, 24 hours a day, seven days a week, with any questions or concerns you might have.

Tobacco Cessation Program

UnitedHealthcare provides a tobacco cessation program to help smokers withdraw from nicotine dependence. By participating in this program, you will more than double your chance of successfully quitting tobacco.

This six (6) month program offers:

- home fulfillment of up to 8 weeks of over-the-counter nicotine replacement therapy, patches or gum;
- toll free telephone access to a dedicated tobacco cessation coach (you will receive up to eight (8) scheduled coaching sessions and may place unlimited calls for support when you have a question);

- help to identify and avoid common reasons why quit attempts fail, including weight gain and stress management; and
- educational articles, quizzes and progress tracking tools designed to provide support through this program.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please call the number on the back of your ID card.

SECTION 8 - EXCLUSIONS: WHAT THE MEDICAL PLAN WILL NOT COVER

What this section includes:

- Services, supplies and treatments that are not Covered Health Services, except as may be specifically provided for in Section 6, *Additional Coverage Details*.

The Plan does not pay Benefits for the following services, treatments or supplies even if they are recommended or prescribed by a provider or are the only available treatment for your condition.

When Benefits are limited within any of the Covered Health Services categories described in Section 6, *Additional Coverage Details*, those limits are stated in the corresponding Covered Health Service category in Section 5, *Plan Highlights*. 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 Section 5, *Plan Highlights*. Please review all limits carefully, as the Plan 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 the EOC says "this includes," or "including but not limiting to", it is not UnitedHealthcare's intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the EOC specifically states that the list "is limited to."

Alternative Treatments

1. acupressure;
2. aromatherapy;
3. hypnotism;
4. massage therapy, unless it is part of a comprehensive therapy program performed by a licensed chiropractor, physical therapist or Physician as a manual therapy technique;
5. rolfing (holistic tissue massage); and
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, acupuncture and osteopathic care for which Benefits are provided as described in Section 6, *Additional Coverage Details*.

Dental

1. dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia), except as identified under *Dental Services - Accident Only* in Section 6, *Additional Coverage Details*;

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 care 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, jawbones or gums. Examples include:

   - extractions (including wisdom teeth);
   - restoration and replacement of teeth;
   - medical or surgical treatments of dental conditions; and
   - 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 6, *Additional Coverage Details*.

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 6, *Additional Coverage Details*.

4. dental braces (orthodontics);

5. dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia except as described under *Dental Services – Accident Only* in Section 6, *Additional Coverage Details*; and

   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 Plan, as identified in Section 6, *Additional Coverage Details*.

6. treatment of congenitally missing (when the cells responsible for the formation of the tooth are absent from birth), malpositioned or supernumerary (extra) teeth, even if part of a Congenital Anomaly such as cleft lip or cleft palate.

Devices, Appliances and Prosthetics

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

2. orthotic appliances and devices that straighten or re-shape a body part, except as described under *Durable Medical Equipment (DME)* in Section 6, *Additional Coverage Details*. This exclusion does not include diabetic footwear which may be covered for a Covered Person with diabetic foot disease or for shoe orthotics as described under Durable Medical Equipment in Section 6, *Additional Coverage Details*.

Examples of excluded orthotic appliances and devices include but are not limited to, foot orthotics and some type of braces, including orthotic braces available over-the-counter.

3. cranial banding;

4. 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; and
   - ultrasonic nebulizers;

5. repairs to prosthetic devices due to misuse, malicious damage or gross neglect;

6. replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items;

7. devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment* in Section 6, *Additional Coverage Details*;

8. oral appliances for snoring.

Drugs

1. prescription drugs 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 UnitedHealthcare, must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting);

3. growth hormone therapy;

4. 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; and

5. over the counter drugs and treatments.

6. New Pharmaceutical Products and/or new dosage forms until the date they are reviewed.

7. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.

8. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.

9. Benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.

Experimental or Investigational or Unproven Services

1. Experimental or Investigational Services and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded, unless the Plan has agreed to cover them as defined in Section 14, *Glossary*. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

   This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 6, *Additional Coverage Details*.

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 6, *Additional Coverage Details*.

2. nail trimming, cutting, or debriding (removal of dead skin or underlying tissue);

3. hygienic and preventive maintenance foot care. Examples include:

   - cleaning and soaking the feet;
   - applying skin creams in order to maintain skin tone; and other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot;

   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;

6. shoe inserts (except for custom molded shoe orthotics);

7. arch supports;

8. shoes (standard or custom), lifts and wedges; and

9. shoe orthotics in excess of the limit described under *Durable Medical Equipment (DME)* in Section 6, *Additional Coverage Details*.

Medical Supplies and Equipment

1. prescribed or non-prescribed medical supplies and disposable supplies. Examples of supplies that are not covered include, but are not limited to:

   - elastic stockings;
   - ace bandages; and
   - gauze and dressings.

   This exclusion does not apply to:

   - compression stockings;
   - surgical dressings and burn garments for wound care;
   - urinary catheters and urological supplies;
   - ostomy bags and related supplies for which Benefits are provided as described under *Ostomy Supplies* in Section 6, *Additional Coverage Details*;
   - disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in Section 6, *Additional Coverage Details*;
   - supplies for renal dialysis equipment and machines; or
   - diabetic supplies for which Benefits are provided as described under *Diabetes Services* in Section 6, *Additional Coverage Details*.

2. tubings nasal cannulas, connectors and masks except when used with Durable Medical Equipment as described under *Durable Medical Equipment* in *Section* 6 *Additional Coverage Details*;

3. the repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect;

4. the replacement of lost or stolen Durable Medical Equipment; and

5. deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover or other items that are not specifically identified in Section 6, *Additional Coverage Details*.

Mental Health and Substance Use Disorder

In addition to all other exclusions listed in this Section 8, *Exclusions*, the exclusions listed directly below apply to services described under *Mental Health Services*, *Neurobiological Disorder - for Autism Spectrum Disorder Services* and/or *Substance Use Disorder Services* in Section 6, *Additional Coverage Details*.

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

2. Health services or supplies that do not meet the definition of a Covered Health Service – see the definition in Section 14, *Glossary*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which the Claims Administrator determines to be all of the following:
   - Medically Necessary.
   - Described as a Covered Health Service in this Plan under Section 5, *Plan Highlights* and Section 6, *Additional Coverage Details*.
   - Not otherwise excluded in this Plan under Section 8, *Exclusions*.

3. Mental Health Services as treatments for R, T and Z code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

4. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep-wake disorders, sexual dysfunctions, feeding disorders, communication disorders, motor disorders, binge eating disorders, neurological disorders and other disorders with a known physical basis.

5. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilic disorder.

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

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

8. Intellectual disabilities as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

9. Mental Health Services as a treatment for other conditions that may be a focus of clinical attention as listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

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

11. Gambling disorders.

12. Substance-induced sexual dysfunction disorders and substance-induced sleep disorders.

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

Nutrition

1. 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);

2. food of any kind, except as described under *Amino Acid-Based Elemental Formula* and *Medical Foods and Tube Feeding Supplies* in Section 6, *Additional Coverage Details*. Foods that are not covered include:

   - enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk, unless they are the only source of nutrition or unless they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU). Infant formula available over the counter is always excluded;
   - foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes;
   - oral vitamins and minerals;
   - meals you can order from a menu, for an additional charge, during an Inpatient Stay; and
   - other dietary and electrolyte supplements; and

3. health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

Personal Care, Comfort or Convenience

1. television;

2. telephone;

3. beauty/barber service;

4. guest service; and

5. supplies, equipment and similar incidentals for personal comfort. Examples include:

   - air conditioners;
   - air purifiers and filters;
   - batteries and battery chargers;
   - breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement;
   - car seats;
   - chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners;
   - dehumidifiers and humidifiers;
   - ergonomically correct chairs;
   - exercise equipment and treadmills;
   - home modifications to accommodate a health need (including, but not limited to, ramps, swimming pools, elevators, handrails, and stair glides);
   - hot tubs, Jacuzzis, saunas and whirlpools;
   - medical alert systems;
   - music devices;
   - non-Hospital beds, comfort beds, motorized beds and mattresses;
   - personal computers;
   - pillows;

- power-operated vehicles;
- radios;
- strollers;
- safety equipment;
- vehicle modifications such as van lifts; and
- video players.

Physical Appearance

1. Cosmetic Procedures, as defined in Section 14, *Glossary*, are excluded from coverage. Examples include:

   - deviated septum-nasal surgery;
   - liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple;
   - pharmacological regimens;
   - nutritional procedures or treatments;
   - tattoo or scar removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures);
   - hair removal or replacement by any means;
   - treatments for skin wrinkles or any treatment to improve the appearance of the skin;
   - treatment for spider veins;
   - skin abrasion procedures performed as a treatment for acne;
   - treatments for hair loss;
   - varicose vein treatment of the lower extremities, when it is considered cosmetic; and
   - replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure;

2. physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, health club memberships and programs, spa treatments, and diversion or general motivation;

3. wigs regardless of the reason for the hair loss except for chemotherapy or radiation therapy for cancer; and

4. treatment of benign gynecomastia (abnormal breast enlargement in males).

Procedures and Treatments

1. medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea (a sleep disorder in which a person regularly stops breathing for 10 seconds or longer);

2. rehabilitation services to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment;

3. speech therapy to treat stuttering, stammering, or other articulation disorders;

4. speech therapy, except when required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, a Congenital Anomaly or autism spectrum disorders as identified under *Rehabilitation Services – Outpatient Therapy* in Section 6, *Additional Coverage Details*;

5. a procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy;

6. excision or elimination of hanging skin on any part of the body (examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty);

7. psychosurgery (lobotomy);

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

9. chelation therapy, except to treat heavy metal poisoning;

10. Chiropractic Treatment to treat a condition unrelated to spinal manipulation and ancillary physiologic treatment rendered to restore/improve motion, reduce pain and improve function, alignment of the vertebral column, such as asthma or allergies;

11. 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;

12. the following treatments for obesity:

    - non-surgical treatment, even if for morbid obesity; and
    - surgical treatment of obesity unless there is a diagnosis of morbid obesity as described under *Obesity Surgery* in Section 6, *Additional Coverage Details*;

13. services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), when the services are considered dental in nature, including oral appliances, surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment and dental restorations, except as described under *Temporomandibular Joint (TMJ) Services* in Section 6, *Additional Coverage Details*;

14. diagnosis or treatment of the jawbones, including orthognathic surgery (procedure to correct underbite or overbite) and jaw alignment, except as treatment of obstructive sleep apnea;

15. upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury, dislocation, tumor or cancer; and

16. breast reduction surgery that is determined to be a Cosmetic Procedure.

    This exclusion does not apply to breast reduction surgery which the Claims Administrator determines is requested to treat a physiologic functional impairment or to coverage required by the Women's Health and Cancer Rights Act of 1998 for which Benefits are described under *Reconstructive Procedures* in Section 6, *Additional Coverage Details*.

Providers

Services:

1. performed by a provider who is a family member by birth or marriage, including your Spouse, brother, sister, parent or child;

2. a provider may perform on himself or herself;

3. performed by a provider with your same legal residence;

4. ordered or delivered by a Christian Science practitioner;

5. Mohel or Rabbi for circumcision;

6. performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license;

7. provided at a diagnostic facility (Hospital or free-standing) without a written order from a provider;

8. which are self-directed to a free-standing or Hospital-based diagnostic facility; and

9. ordered by a provider affiliated with a diagnostic facility (Hospital or free-standing), when that provider is not actively involved in your medical care:

    - prior to ordering the service; or
    - after the service is received.

    This exclusion does not apply to mammography testing.

Reproduction

1. The following infertility services: Artificial Insemination and Intrauterine Insemination:

    - When the Member or Spouse has undergone elective sterilization with or without reversal.

    - Surrogates and gestational carriers are not covered in any case.

    - For a Member whose Spouse is of the opposite sex, when the service involves the use of donor egg(s), donor sperm or donor embryo(s).

- When the service involves the participation of a Domestic Partner or common law Spouse, except in states that recognize the legality of those relationships.

- When the Member does not meet the conditions of coverage as described in the Infertility Services section of the Description of Covered Services.

Additionally, artificial insemination and intrauterine insemination benefits do not include benefits for cryopreservation, storage, and or thawing of sperm, egg(s), or embryo(s).

2. The following infertility services: In-vitro fertilization:

   - When the Member or Spouse has undergone elective sterilization with or without reversal.

   - Surrogates and gestational carriers are not covered in any case.

   - For a Member whose Spouse is of the opposite sex, when the service involves the use of donor egg(s), donor sperm or donor embryo(s).

   - When the service involves the participation of a Domestic Partner or common law Spouse, except in states that recognize the legality of those relationships.

   - When the Member does not meet the conditions of coverage as described in the Infertility Services section of the Description of Covered Services.

Additionally, in-vitro fertilization benefits do not include benefits for cryopreservation, storage, and or thawing of sperm, egg(s), or embryo(s).

3. The following infertility treatment-related services:

   - gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT) unless related to IVF;
   - sex selection services; and
   - the cost of any prescription medication treatment for in vitro fertilization, gamete intrafallopian transfer (GIFT) procedures and zygote intrafallopian transfer (ZIFT) procedures, except as described under *Infertility Services* in Section 6, *Additional Coverage Details*;

4. host uterus;

5. the reversal of voluntary sterilization for vasectomy and tubal ligation;

6. artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes;

7. elective surgical, non-surgical or drug induced Pregnancy termination, after the first trimester;

8. services provided by a doula (labor aide);

9. parenting, pre-natal or birthing classes; and

10. fetal surgery unless as described under Congenital Heart Disease.

Services Provided under Another Plan

Services for which coverage is available:

1. under another plan, except for Eligible Expenses payable as described in Section 10, *Coordination of Benefits (COB)*;

2. under workers' compensation, no-fault automobile coverage or similar legislation if you could elect it, or could have it elected for you;

3. while on active military duty; and

4. for treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably accessible.

Transplants

1. health services for organ and tissue transplants, except as identified under *Transplantation Services* in Section 6*, Additional Coverage Details* unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines;

2. mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available); and

3. donor costs for organ or tissue transplantation to another person (these costs may be payable through the recipient's benefit plan).

Travel

1. travel or transportation expenses, even if ordered by a Physician, except as identified under *Travel and Lodging* in Section 6, *Additional Coverage Details*. Additional travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in Section 6, *Additional Coverage Details*.

Treatment of Gender Dysphoria (Gender Identity Disorder)

1. nipple/areola reconstruction, except in connection with a covered augmentation mammoplasty or mastectomy;

2. breast enlargement procedures, except in connection with a covered augmentation mammoplasty;

3. brow lift;

4. cheek implants;
5. chin/nose implants;
6. collagen injections;
7. electrolysis;
8. facial bone reconstruction;
9. face/forehead lift;
10. hair removal/hairplasty/hair transplantation;
11. jaw shortening/sculpturing/facial bone reduction;
12. lip reduction/enhancement;
13. liposuction;
14. neck tightening;
15. reversal of genital or breast surgery or reversal of surgery to revise secondary sex characteristics;
16. voice modification surgery;
17. voice therapy/voice lessons;
18. rhinoplasty;
19. removal of redundant skin, except in connection with a covered surgery;
20. replacement of tissue expander with permanent prosthesis testicular insertion, except as a component of a covered placement of a testicular prosthesis;
21. second stage phalloplasty;
22. surgical correction of hydraulic abnormality of inflatable (multi-component) prosthesis including pump and/or cylinders and/or reservoir;
23. testicular prostheses, except as a component of a covered placement of a testicular prosthesis (subsequent replacement or correction of such prosthesis subject to rules and limitations applicable to all prosthetic devices);
24. blepharoplasty;
25. penile prosthesis (non-inflatable/inflatable), except in connection with a covered phalloplasty (implantation of the prosthesis shall not be considered a second stage

phalloplasty) in a female-to-male transition (subsequent replacement or correction of such prosthesis subject to rules and limitations applicable to all prosthetic devices);

26. testicular expanders, except as a component of a covered placement of a testicular prosthesis;

27. laryngoplasty;

28. mastopexy;

29. abdominoplasty; and

30. treatment received outside of the United States.

Types of Care

1. Custodial Care as defined in Section 14, *Glossary* or maintenance care;

2. Domiciliary Care, as defined in Section 14, *Glossary;*

3. multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain;

4. Private Duty Nursing received on an inpatient basis;

5. respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under *Hospice Care* in Section 6, *Additional Coverage Details*;

6. rest cures;

7. services of personal care attendants; and

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

Vision and Hearing

1. implantable lenses used only to correct a refractive error (such as Intacs corneal implants);

2. purchase cost and associated fitting charges for eyeglasses or contact lenses except as described under *Vision Examinations and Vision Hardware* in Section 6, *Additional Coverage Details*;

3. bone anchored hearing aids except when either of the following applies:

   - for Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or

- for Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

The Plan will not pay for more than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled in this Plan. In addition, repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage are not covered, other than for malfunctions;

4. eye exercise or vision therapy; and

5. surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.

All Other Exclusions

1. autopsies and other coroner services and transportation services for a corpse;

2. charges for:

   - missed appointments;
   - room or facility reservations;
   - completion of claim forms; or
   - record processing.

3. charges prohibited by federal anti-kickback or self-referral statutes;

4. diagnostic tests that are:

   - delivered in a setting other than a Physician's office or health care facility; and
   - self-administered home diagnostic tests, including but not limited to HIV and Pregnancy tests;

5. expenses for health services and supplies:

   - that do not meet the definition of a Covered Health Service in Section 14, *Glossary*;
   - that are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone;
   - that are received after the date your coverage under this Plan ends, including health services for medical conditions which began before the date your coverage under the Plan ends;
   - 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 this Benefit Plan;
   - that exceed Eligible Expenses or any specified limitation in this EOC; or

- for which an Out-of-Network provider waives the Copay, Annual Deductible or Coinsurance amounts;

6. foreign language and sign language services;

7. long term (more than 30 days) storage of blood, umbilical cord or other material. Examples include cryopreservation of tissue, blood and blood products;

8. health services and supplies that do not meet the definition of a Covered Health Service – see the definition in Section 14, *Glossary*. Covered Health Services are those health services including services, supplies or Prescription Drugs, which the Claims Administrator determines to be all of the following:

   - Medically Necessary;
   - described as a Covered Health Service in this Evidence of Coverage; and
   - not otherwise excluded in this Evidence of Coverage under this Section 8, *Exclusions*.

9. health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services the Plan would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.

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

10. physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:

    - required solely for purposes of education, camp, travel, career or employment, insurance, marriage or adoption; or as a result of incarceration;
    - conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in Section 6, *Additional Coverage Details*;
    - related to judicial or administrative proceedings or orders; or
    - required to obtain or maintain a license of any type.

SECTION 9 - CLAIMS PROCEDURES

What this section includes:
- How In-Network and Out-of-Network claims work; and
- What to do if your claim is denied, in whole or in part.

In-Network Benefits

In general, if you receive Covered Health Services from an In-Network provider, UnitedHealthcare will pay the Physician or facility directly. If an In-Network provider bills you for any Covered Health Service other than your Copay or Coinsurance, please contact the provider or call UnitedHealthcare at the phone number on your ID card for assistance.

Keep in mind, you are responsible for paying any Copay or Coinsurance owed to an In-Network provider at the time of service, or when you receive a bill from the provider.

Out-of-Network Benefits

If you receive a bill for Covered Health Services from an Out-of-Network provider, you (or the provider if they prefer) must send the bill to UnitedHealthcare for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to UnitedHealthcare at the address on the back of your ID card.

If Your Provider Does Not File Your Claim

You can obtain a claim form by visiting **www.myuhc.com**, calling the toll-free number on your ID card or contacting your Agency Benefit Coordinator or the Employee Benefits Division. If you do not have a claim form, simply attach a brief letter of explanation to the bill, and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

- your name and address;
- the patient's name, age and relationship to the Employee;
- the number as shown on your ID card;
- the name, address and tax identification number of the provider of the service(s);
- a diagnosis from the Physician;
- the date of service; and
- an itemized bill from the provider that includes:
  - the Current Procedural Terminology (CPT) codes;
  - a description of, and the charge for, each service;
  - the date the Sickness or Injury began; and

- 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 and address of the other carrier(s).

Failure to provide all the information listed above may delay any reimbursement that may be due you.

For medical claims, the above information should be filed with UnitedHealthcare at the address on your ID card.

After UnitedHealthcare has processed your claim, you will receive payment for Benefits that the Plan allows. It is your responsibility to pay the Out-of-Network provider the charges you incurred, including any difference between what you were billed and what the Plan paid.

You may not assign your Benefits under the Plan to an Out-of-Network provider without UnitedHealthcare's consent. When you assign your Benefits under the Plan to an Out-of-Network provider with UnitedHealthcare's consent, and the Out-of-Network provider submits a claim for payment, you and the Out-of-Network provider represent and warrant that the Covered Health Services were actually provided and were medically appropriate.

When UnitedHealthcare has not consented to an assignment, UnitedHealthcare will send the reimbursement directly to you (the Employee) for you to reimburse the Out-of-Network provider upon receipt of their bill. However, UnitedHealthcare reserves the right, in its discretion, to pay the Out-of-Network provider directly for services rendered to you. When exercising its discretion with respect to payment, UnitedHealthcare may consider whether you have requested that payment of your Benefits be made directly to the Out-of-Network provider. Under no circumstances will UnitedHealthcare pay Benefits to anyone other than you or, in its discretion, your provider. Direct payment to an Out-of-Network provider shall not be deemed to constitute consent by UnitedHealthcare to an assignment or to waive the consent requirement. When UnitedHealthcare in its discretion directs payment to an Out-of-Network provider, you remain the sole beneficiary of the payment, and the Out-of-Network provider does not thereby become a beneficiary. Accordingly, legally required notices concerning your Benefits will be directed to you, although UnitedHealthcare may in its discretion send information concerning the Benefits to the Out-of-Network provider as well. If payment to an Out-of-Network provider is made, the Plan reserves the right to offset Benefits to be paid to the provider by any amounts that the provider owes the Plan, pursuant to *Refund of Overpayments* in Section 10, *Coordination of Benefits*.

Health Statements

Each month in which UnitedHealthcare processes at least one claim for you or a covered Dependent, you will receive a Health Statement in the mail. Health Statements make it easy for you to manage your family's medical costs by providing claims information in easy-to-understand terms.

If you would rather track claims for yourself and your covered Dependents online, you may do so at **www.myuhc.com**. You may also elect to discontinue receipt of paper Health Statements by making the appropriate selection on this site.

Explanation of Benefits (EOB)

You may request that UnitedHealthcare send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. If you would like paper copies of the EOBs, you may call the toll-free number on your ID card to request them. You can also view and print all of your EOBs online at **www.myuhc.com**. See Section 14, *Glossary* for the definition of Explanation of Benefits.

Important - Timely Filing of Out-of-Network Claims
All claim forms for Out-of-Network services must be submitted within 12 months after the date of service. Otherwise, the Plan will not pay any Benefits for that Eligible Expense, or Benefits will be reduced, as determined by UnitedHealthcare. This 12-month requirement does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Claim Denials and Appeals

What to Do First

If your question or concern is about a benefit determination, you may informally contact Customer Service before requesting a formal appeal. If the Customer Service representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination you may appeal it as described below, without first informally contacting Customer Service. If you first informally contact Customer Service and later wish to request a formal appeal in writing, you should contact Customer Service and request an appeal. If you request a formal appeal, a Customer Service representative will provide you with the appropriate address of the Claims Administrator.

If you are appealing an urgent care claim denial, please refer to the "Urgent Appeals that Require Immediate Action" section below and contact Customer Service immediately. The Customer Service telephone number is shown on your ID card. Customer Service representatives are available to take your call.

How to Appeal a Claim Decision

If you wish to appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefit determination. You do not need to submit Urgent Care appeals in writing.

Your request should include:

- The patient's name and the identification number from the ID card;
- The provider's name;
- The date(s) of medical service(s);

- The reason you believe the claim should be paid; and
- Any documentation or other written information to support your request for claim payment.

Your appeal request must be submitted to the Claims Administrator within 180 days after you receive the claim denial.

Requests for Review of Denied Claims, Appeals, and Notice of Complaints:

Name and Address for Submitting Requests:

UnitedHealthcare - Appeals
P.O. Box 30432
Salt Lake City, UT 84130-0432

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. The Claims Administrator 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 your request and free of charge, you have the right to reasonable access to (including copies of) all documents, records, and other information relevant to your claim for Benefits.

Appeals Determinations

Pre-Service Requests for Benefits and Post-Service Claim Appeals

You will be provided written or electronic notification of decision on your appeal as follows:

For appeals of pre-service requests for Benefits, the appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for appeal of a denied request for Benefits.

For appeals of post-service claims, the appeal will be conducted and you will be notified by the Claims Administrator of the decision within 60 days from receipt of a request for appeal of a denied claim.

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

The Claims Administrator has the sole and absolute discretionary authority to interpret and administer the Plan, and these decisions are conclusive and binding on all persons affected thereby.

Please note that a decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate 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 the Claims Administrator as soon as possible. The Claims Administrator will provide you with a written or electronic determination within 24 hours following receipt by the Claims Administrator of your request for review of the determination taking into account the seriousness of your condition.

For urgent requests for Benefits appeals, we have delegated to the Claims Administrator the sole and absolute discretionary authority to interpret and administer the Plan. These decisions are conclusive and binding on all persons affected thereby.

External Review Rights

If, after exhausting your internal appeals through the Claims Administrator, you are not satisfied with the final internal appeals determination, you may have a right to have the decision reviewed by the Maryland Insurance Administration (MIA) if the decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested by submitting a request. For such cases, please submit your request, along with any additional information you want considered, within 120 days of the date you receive the letter of final internal appeals determination to:

Maryland Insurance Administration
Appeals and Grievance Unit
200 St. Paul Place, Suite 2700
Baltimore, MD 21202
Phone: (410) 468-2000
Toll-free: (800) 492-6116
TTY: (800)-735-2258
Fax: (410) 468-2270

If your claim is denied because the service was not a covered service it may not be eligible for an independent, external review. If you still disagree with the denial, however, you may contact the State of Maryland Employee Benefits Division at the following:

Employee Benefits Division
Attn: Adverse Determinations
301 West Preston Street, Room 510
Baltimore, MD 21201

Telephone: (410) 767-4775
Toll-free: 1-800-307-8283
Facsimile: (401) 333-7104

All requests for final appeals must be made within 120 days of the date you receive the final internal appeals determination. You, your treating Physician or an authorized designated representative may request the external review.

If there is any information or evidence you or your Physician wish to submit in support of the request that was not previously provided, you may include this information with the request for the final appeal. A decision will be made within applicable timeframes, and the decision will be in writing. If additional information is necessary to make a decision, this time period may be extended. The final appeal review process will be expedited if you meet the criteria for an expedited external review as defined by applicable law.

If the external review decision is to approve payment or referral, the Plan will accept the decision and provide Benefits for such service or procedure in accordance with the terms and conditions of the Plan. If the external review decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the service or procedure.

You may contact the Maryland Insurance Administration at (800) 492-6116 for more information regarding your final appeal rights.

Limitation of Action

You cannot bring any legal action against State of Maryland or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against State of Maryland or the Claims Administrator, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against State of Maryland or the Claims Administrator.

You cannot bring any legal action against State of Maryland or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against State of Maryland or the Claims Administrator you must do so within three years of the date you are notified of our final decision on your appeal or you lose any rights to bring such an action against State of Maryland or the Claims Administrator.

Availability of Consumer Assistance/Ombudsman Services

In addition, there may be other resources available to help you understand the appeals process. For questions about your rights or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

THERE IS HELP AVAILABLE TO YOU IF YOU WISH TO DISPUTE THE DECISION OF THE PLAN ABOUT PAYMENT FOR HEALTH CARE SERVICES.

You or your authorized representative may contact the Health Advocacy Unit of Maryland's Consumer Protection Division:

Health Education and Advocacy Unit
Division of Consumer Protection
Office of the Attorney General
200 St. Paul Place
Baltimore, MD 21202-2272
Phone: (410) 528-1840 or toll-free (877) 261-8807
Fax: (410) 576-6571
E-mail: heau@oag.state.md.us

The Health Advocacy Unit can help you and your health care provider file an appeal under the Claims Administrator's appeal process. 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 grievance process.

SECTION 10 - COORDINATION OF BENEFITS (COB)

What this section includes:

- How your Benefits under this Plan coordinate with other medical plans;
- How coverage is affected if you become eligible for Medicare; and
- Procedures in the event the Plan overpays Benefits.

Coordination of Benefits (COB) applies to you if you are covered by more than one health benefits plan, including any one of the following:

- another employer sponsored health benefits plan;
- a medical component of a group long-term care plan, such as skilled nursing care;
- no-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy;
- medical payment benefits under any premises liability or other types of liability coverage; or
- Medicare or other governmental health benefit.

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the primary plan.

Don't forget to update your Dependents' Medical Coverage Information
Avoid delays on your Dependent claims by updating your Dependent's medical coverage information. Just log on to **www.myuhc.com** or call the toll-free number on your ID card to update your COB information. You will need the name of your Dependent's other medical coverage, along with the policy number.

Determining Which Plan is Primary

If you are covered by two or more plans, the benefit payment follows the rules below in this order:

- this Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy;
- when you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first;
- a plan that covers a person as an Employee pays benefits before a plan that covers the person as a Dependent;

- if you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first;
- your Dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:
  - the parents are married or living together whether or not they have ever been married and not legally separated; or
  - a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage;
- if two or more plans cover a Dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:
  - the parent with custody of the child; then
  - the Spouse of the parent with custody of the child; then
  - the parent not having custody of the child; then
  - the Spouse of the parent not having custody of the child;
- plans for active Employees pay before plans covering laid-off or retired Employees;
- the plan that has covered the individual claimant the longest will pay first; only expenses normally paid by the Plan will be paid under COB; and
- finally, if none of the above rules determines which plan is primary or secondary, the allowed benefits 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.

The following examples illustrate how the Plan determines which plan pays first and which plan pays second.

Determining Primary and Secondary Plan - Examples
1) Let's say you and your Spouse both have family medical coverage through your respective employers. You are unwell and go to see a Physician. Since you're covered as an Employee under this Plan, and as a Dependent under your Spouse's plan, this Plan will pay Benefits for the Physician's office visit first.
2) Again, let's say you and your Spouse both have family medical coverage through your respective employers. You take your Dependent child to see a Physician. This Plan will look at your birthday and your Spouse's birthday to determine which plan pays first. If you were born on June 11 and your Spouse was born on May 30, your Spouse's plan will pay first.

When This Plan is Secondary to any Plan other than Medicare

When this Plan is secondary to any plan other than Medicare, it determines the amount it will pay for a Covered Health Service by following the steps below.

- the Plan determines the amount it would have paid based on its contract; or
- if this Plan would have paid more than the primary plan paid, the Plan will pay the difference less any applicable Deductible, Coinsurance and Copay requirements of the Plan.

You will be responsible for any Coinsurance or Deductible and/or Copay payments as part of the COB payment.

When This Plan is Secondary to Medicare

When this Plan is secondary to Medicare, it determines the amount it will pay for a Covered Health Service by following the steps below.

- when Benefit for covered services are paid by Medicare primary, UnitedHealthcare will not duplicate those payments; and
- if this Plan would have paid more than the primary plan paid, the Plan will pay the difference less any applicable Deductible and Coinsurance requirements of the Plan.

You will be responsible for any Coinsurance or Deductible payments as part of the COB payment. Copays will be waived.

Determining the Allowed Benefit If This Plan is Secondary

If this Plan is secondary and the expense meets the definition of a Covered Health Service under this Plan, the allowed benefit is the primary plan's In-Network rate. If the primary plan bases its reimbursement on reasonable and customary charges, the allowed benefit is the primary plan's reasonable and customary charge. If both the primary plan and this Plan do not have a contracted rate, the allowed benefit will be the greater of the two plans' reasonable and customary charges.

When the provider is an In-Network provider for both the primary plan and this Plan, the allowed benefit is the primary plan's In-Network rate. When the provider is an In-Network provider for the primary plan and an Out-of-Network provider for this Plan, the allowed benefit is the primary plan's In-Network rate. When the provider is an Out-of-Network provider for the primary plan and an In-Network provider for this Plan, the allowed benefit is the reasonable and customary charges allowed by the primary plan. When the provider is an Out-of-Network provider for both the primary plan and this Plan, the allowed benefit is the greater of the two Plans' reasonable and customary charges.

What is an allowed benefit?
For purposes of COB, an allowed benefit is a health care expense that meets the definition of a Covered Health Service under this Plan.

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

To the extent permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- Employees with active current employment status age 65 or older and their Spouses age 65 or older; and
- individuals with end-stage renal disease, for a limited period of time.

Determining the Allowed Benefit When This Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the allowed benefit, as long as the provider accepts Medicare. If the provider does not accept Medicare, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare) will be the allowed benefit. Medicare payments, combined with Plan Benefits, will not exceed 100% of the total allowed benefit.

If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, Benefits payable under this Plan will be reduced by the amount that would have been paid if you had been enrolled in Medicare.

When Medicare is primary, the following are waived:

- Copayments; and
- Care Coordination prior authorization requirements.

Medicare Cross-Over Program

The Plan offers a Medicare Cross-over Program for Medicare Part B and Durable Medical Equipment (DME) claims. If you enroll for this program, you no longer have to file a separate claim with the Plan to receive secondary benefits for these expenses.

Once the Medicare Part B and DME carriers have reimbursed your health care provider, the Medicare carrier will electronically submit the necessary information to the Claims Administrator to process the balance of your claim under the provisions of this Plan.

To participate in the Medicare Cross-over Program, you must complete a special form authorizing this service and submit it to the Claims Administrator. Your Spouse also can enroll for this program, as long as he or she is eligible for Medicare and this Plan is your only secondary medical coverage.

You can verify that the automated cross-over is in place when your copy of the explanation of Medicare benefits (EOMB) states your claim has been forwarded to your secondary carrier. Until this message appears, you must continue to file secondary claims with the Claims Administrator.

This cross-over process does not apply to expenses under Part A of Medicare (hospital expenses) or expenses that Medicare does not cover. You must continue to file claims for these expenses.

For information about enrollment or if you have questions about the program, call the telephone number listed on the back of your ID card.

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. The Plan Administrator may get the facts needed 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.

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

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that UnitedHealthcare should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Group may recover the amount in the form of salary, wages, or benefits payable under any Group-sponsored benefit plans, including this Plan. The Group also reserves the right to recover any overpayment by legal action or offset payments on future Eligible Expenses.

If the Plan overpays a health care provider, UnitedHealthcare reserves the right to recover the excess amount, from the provider pursuant to *Refund of Overpayments*, below.

Refund of Overpayments

If the Plan pays for 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 the Plan if:

- the Plan's obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid by the Covered Person, but all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person;
- all or some of the payment the Plan made exceeded the Benefits under the Plan; or
- all or some of the payment was made in error.

The amount that must be refunded equals the amount the Plan paid in excess of the amount that should have paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help the Plan 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 owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits for the Covered Person that are payable under the Plan; (ii) future Benefits that are payable to other Covered Persons under the Plan; or (iii) future benefits that are payable for services provided to persons under other plans for which UnitedHealthcare makes payments, with the understanding that UnitedHealthcare will then reimburse the Plan the amount of the reallocated payment. The reallocated payment amount will equal the amount of the required refund or, if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan. The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

SECTION 11 - SUBROGATION AND REIMBURSEMENT

What this section includes:
- How your Benefits are impacted if you suffer a Sickness or Injury caused by a third party.

The Plan has a right to subrogation and reimbursement.

Subrogation applies when the plan has paid Benefits on your behalf for a Sickness or Injury for which a third party is alleged to be responsible. The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the Benefits that the Plan has paid that are related to the Sickness or Injury for which a third party is alleged to be responsible.

Subrogation - Example
Suppose you are injured in a car accident that is not your fault, and you receive Benefits under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those Benefits.

The right to reimbursement means that if a third party causes or is alleged to have caused a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any Benefits you received for that Sickness or Injury.

Reimbursement - Example
Suppose you are injured in a boating accident that is not your fault, and you receive Benefits under the Plan as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the plan 100% of any Benefits you received to treat your injuries.

The following persons and entities are considered third parties:

- a person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages;
- any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages;
- the Plan Sponsor (for example workers' compensation cases);
- any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators; and

- any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable;
  - providing any relevant information requested by the Plan;
  - signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim;
  - responding to requests for information about any accident or injuries;
  - making court appearances;
  - obtaining the Plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses; and
  - complying with the terms of this section.

  Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to Hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.

- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.

- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or

characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.

- Benefits paid by the Plan may also be considered to be Benefits advanced.
- If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you shall hold those funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the Benefits the Plan has paid.
- The Plan's rights to recovery will not be reduced due to your own negligence.
- Upon the Plan's request, you will assign to the Plan all rights of recovery against third parties, to the extent of the Benefits the Plan has paid for the Sickness or Injury.
- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party and filing suit in your name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If a third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.
- The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights

and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Right of Recovery

The Plan also has the right to recover benefits it has paid on you or your Dependent's behalf that were:

- made in error;
- due to a mistake in fact;
- advanced during the time period of meeting the calendar year Deductible; or
- advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.

Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

If the Plan provides a Benefit for you or your Dependent that exceeds the amount that should have been paid, the Plan will:

- require that the overpayment be returned when requested, or
- reduce a future benefit payment for you or your Dependent by the amount of the overpayment.

If the Plan provides an advancement of benefits to you or your Dependent during the time period of meeting the Deductible and/or meeting the Out-of-Pocket Maximum for the calendar year, the Plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover Benefits it has advanced by:

- submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan; and
- conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

SECTION 12 - WHEN COVERAGE ENDS

What this section includes:
- Circumstances that cause coverage to end; and
- How to continue coverage after it ends.

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.

When your coverage ends, State of Maryland will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, Benefits are not provided for health services that you receive after coverage ended, even if the underlying medical condition occurred before your coverage ended.

Your coverage under the Plan will end on the earliest of:

- the 15th of the month if your employment with the Group ends before the 15th of the month;
- last day of the month your employment with the Group ends if your employment with the Group ends on or after the 15th of the month;
- the date the Plan ends; or
- the end of the pay period covered by your last deduction or payment.

Coverage for your eligible Dependents will end on the earliest of:

- the date your coverage ends;
- at the end of the pay period covered by your last deduction or payment;
- the 15th of the month or the last day of the month based on when your Dependent no longer qualifies as a Dependent under this Plan; or
- the end of the month in which your eligible Dependent turns age 26.

Other Events Ending Your Coverage

The Plan will provide prior written notice to you that your coverage will end on the date identified in the notice if:

- you commit an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact including, but not limited to, false information relating to another person's eligibility or status as a Dependent; or
- you commit an act of physical or verbal abuse that imposes a threat to State of Maryland's staff, UnitedHealthcare's staff, a provider or another Covered Person.

Note: State of Maryland has the right to require that you pay back Benefits State of Maryland paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.

Coverage for a Disabled Child

If an unmarried enrolled Dependent child with a mental or physical disability reaches an age when coverage would otherwise end, the Plan will continue to cover the child, as long as:

- the child is unable to be self-supporting due to a mental or physical handicap or disability;
- the child depends mainly on you for support;
- you provide to State of Maryland proof of the child's incapacity and dependency within 60 days of the date coverage would have otherwise ended because the child reached a certain age; and
- you provide proof, upon State of Maryland's request, that the child continues to meet these conditions.

The proof might include medical examinations at State of Maryland's expense. However, you will not be asked for this information more than once a year. If you do not supply such proof within 60 days, the Plan will no longer pay Benefits for that child.

Coverage will continue, as long as the enrolled Dependent is incapacitated and dependent upon you, unless coverage is otherwise terminated in accordance with the terms of the Plan.

Continuing Coverage Through COBRA

If you lose your Plan coverage, you may have the right to extend it under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as defined in Section 14, *Glossary*.

Continuation coverage under COBRA is available only to Plans that are subject to the terms of COBRA. You can contact your Plan Administrator to determine if State of Maryland is subject to the provisions of COBRA.

Continuation Coverage under Federal Law (COBRA)

Much of the language in this section comes from the federal law that governs continuation coverage. You should call your Plan Administrator if you have questions about your right to continue coverage.

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

- an Employee;

- an Employee's enrolled Dependent, including with respect to the Employee's children, a child born to or placed for adoption with the Employee during a period of continuation coverage under federal law; or
- an Employee's former Spouse.

Qualifying Events for Continuation Coverage under COBRA

The following table outlines situations in which you may elect to continue coverage under COBRA for yourself and your Dependents, and the maximum length of time you can receive continued coverage. These situations are considered qualifying events.

If Coverage Ends Because of the Following Qualifying Events:	You May Elect COBRA:		
	For Yourself	For Your Spouse	For Your Child(ren)
Your work hours are reduced	18 months	18 months	18 months
Your employment terminates for any reason (other than gross misconduct)	18 months	18 months	18 months
You or your family member become eligible for Social Security disability benefits at any time within the first 60 days of losing coverage[1]	29 months	29 months	29 months
You die	N/A	36 months	36 months
You divorce (or legally separate) [2]	N/A	36 months	36 months
Your child is no longer an eligible family member (e.g., reaches the maximum age limit)	N/A	N/A	36 months
You become entitled to Medicare	N/A	See table below	See table below

[1]Subject to the following conditions: (i) notice of the disability must be provided within the latest of 60 days after a). the determination of the disability, b). the date of the qualifying event, c). the date the Qualified Beneficiary would lose coverage under the Plan, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months over the original 18 months; and (iii) if the Qualified Beneficiary entitled to the 11 months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

[2]A dependent spouse may also be eligible for COBRA if he or she is terminated from coverage by the employee spouse in anticipation of divorce or separation. If this occurs, the dependent spouse would be entitled to the same COBRA rights as a divorced spouse.

How Your Medicare Eligibility Affects Dependent COBRA Coverage

The table below outlines how your Dependents' COBRA coverage is impacted if you become entitled to Medicare.

If Dependent Coverage Ends When:	You May Elect COBRA Dependent Coverage For Up To:
You become entitled to Medicare and don't experience any additional qualifying events	18 months
You become entitled to Medicare, after which you experience a second qualifying event* before the initial 18-month period expires	36 months
You experience a qualifying event*, after which you become entitled to Medicare before the initial 18-month period expires; and, if absent this initial qualifying event, your Medicare entitlement would have resulted in loss of Dependent coverage under the Plan	36 months

* Your work hours are reduced or your employment is terminated for reasons other than gross misconduct.

Getting Started

You will be notified by mail if you become eligible for COBRA coverage as a result of a reduction in work hours or termination of employment. The notification will give you instructions for electing COBRA coverage, and advise you of the monthly cost. Your monthly cost is the full cost, including both Employee and Employer costs, plus a 2% administrative fee or other cost as permitted by law.

You will have up to 60 days from the date you receive notification or 60 days from the date your coverage ends to elect COBRA coverage, whichever is later. You will then have an additional 45 days to pay the cost of your COBRA coverage, retroactive to the date your Plan coverage ended.

During the 60-day election period, the Plan will, only in response to a request from a provider, inform that provider of your right to elect COBRA coverage, retroactive to the date your COBRA eligibility began.

While you are a participant in the medical Plan under COBRA, you have the right to change your coverage election:

- during Open Enrollment; and

- following a change in family status, as described under *Changing Your Coverage* in Section 2*, Introduction*.

Notification Requirements

If your covered Dependents lose coverage due to divorce, legal separation, or loss of Dependent status, you or your Dependents must notify the Plan Administrator within 60 days of the latest of:

- the date of the divorce, legal separation or an enrolled Dependent's loss of eligibility as an enrolled Dependent;
- the date your enrolled Dependent would lose coverage under the Plan; or
- the date on which you or your enrolled Dependent are informed of your obligation to provide notice and the procedures for providing such notice.

You or your Dependents must also notify the Plan Administrator when a qualifying event occurs that will extend continuation coverage.

If you or your Dependents fail to notify the Plan Administrator of these events within the 60 day period, the Plan Administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If you are continuing coverage under federal law, you must notify the Plan Administrator within 60 days of the birth or adoption of a child.

Once you have notified the Plan Administrator, you will then be notified by mail of your election rights under COBRA.

Notification Requirements for Disability Determination

If you extend your COBRA coverage beyond 18 months because you are eligible for disability benefits from Social Security, you must provide your Agency Benefit Coordinator or the Employee Benefits Division with notice of the Social Security Administration's determination within 60 days after you receive that determination, and before the end of your initial 18-month continuation period.

The notice requirements will be satisfied by providing written notice to the Plan Administrator. The contents of the notice must be such that the Plan Administrator is able to determine the covered Employee and qualified beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event occurred.

Trade Act of 2002

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain Employees who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These Employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the

first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If an Employee qualifies or may qualify for assistance under the Trade Act of 1974, he or she should contact the Plan Administrator for additional information. The Employee must contact the Plan Administrator promptly after qualifying for assistance under the Trade Act of 1974 or the Employee will lose his or her special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that Plan coverage was lost, but begins on the first day of the special second election period.

When COBRA Ends

COBRA coverage will end before the maximum continuation period, on the earliest of the following dates:

- the date, after electing continuation coverage, that coverage is first obtained under any other group health plan;
- the date, after electing continuation coverage, that you or your covered Dependent first becomes entitled to Medicare;
- the date coverage ends for failure to make the first required premium payment (premium is not paid within 45 days);
- the date coverage ends for failure to make any other monthly premium payment (premium is not paid within 30 days of its due date);
- the date the entire Plan ends; or
- the date coverage would otherwise terminate under the Plan as described in the beginning of this section.

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

Uniformed Services Employment and Reemployment Rights Act

An Employee who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Plan coverage for the Employee and the Employee's Dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

The terms "Uniformed Services" or "Military Service" mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified to continue coverage pursuant to the USERRA, Employees may elect to continue coverage under the Plan by notifying the Plan Administrator in advance, and providing payment of any required contribution for the health coverage. This may include the amount the Plan Administrator normally pays on an Employee's behalf. If an Employee's Military Service is for a period of time less than 31 days, the Employee may not be required to pay more than the regular contribution amount, if any, for continuation of health coverage.

An Employee may continue Plan coverage under USERRA for up to the lesser of:

- the 24 month period beginning on the date of the Employee's absence from work; or
- the day after the date on which the Employee fails to apply for, or return to, a position of employment.

Regardless of whether an Employee continues health coverage, if the Employee returns to a position of employment, the Employee's health coverage and that of the Employee's eligible Dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on an Employee or the Employee's eligible Dependents in connection with this reinstatement, unless a Sickness or Injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should call the Plan Administrator if you have questions about your rights to continue health coverage under USERRA.

SECTION 13 - OTHER IMPORTANT INFORMATION

What this section includes:

- Qualified Medical Child Support Orders (QMCSOs);
- Your relationship with UnitedHealthcare and State of Maryland;
- Relationships with providers;
- Interpretation of Benefits;
- Information and records;
- Incentives to providers and you;
- The future of the Plan; and
- How to access the official Plan documents.

Qualified Medical Child Support Orders (QMCSOs)

A qualified medical child support order (QMCSO) is a judgment, decree or order issued by a court or appropriate state agency that requires a child to be covered for medical benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement.

If the Plan receives a medical child support order for your child that instructs the Plan to cover the child, the Plan Administrator will review it to determine if it meets the requirements for a QMCSO. If it determines that it does, your child will be enrolled in the Plan as your Dependent, and the Plan will be required to pay Benefits as directed by the order.

You may obtain, without charge, a copy of the procedures governing QMCSOs from the Plan Administrator.

Note: A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

Your Relationship with UnitedHealthcare and State of Maryland

In order to make choices about your health care coverage and treatment, State of Maryland believes that it is important for you to understand how UnitedHealthcare interacts with the Plan Sponsor's benefit Plan and how it may affect you. UnitedHealthcare helps administer the Plan Sponsor's benefit Plan in which you are enrolled. UnitedHealthcare does not provide medical services or make treatment decisions. This means:

- State of Maryland and UnitedHealthcare do not decide what care you need or will receive. You and your Physician make those decisions;
- UnitedHealthcare communicates to you decisions about whether the 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 EOC); and

- 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.

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

Relationship with Providers

The relationships between State of Maryland, UnitedHealthcare and In-Network providers are solely contractual relationships between independent contractors. In-Network providers are not State of Maryland's agents or employees, nor are they agents or employees of UnitedHealthcare. State of Maryland and any of its employees are not agents or employees of In-Network providers, nor are UnitedHealthcare and any of its employees agents or employees of In-Network providers.

State of Maryland and UnitedHealthcare do not provide health care services or supplies, nor do they practice medicine. Instead, State of Maryland and UnitedHealthcare arrange for health care providers to participate in a Network and pay Benefits. In-Network providers are independent practitioners who run their own offices and facilities. The Claims Administrator's 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 State of Maryland's employees nor are they employees of UnitedHealthcare. State of Maryland and UnitedHealthcare do not have any other relationship with In-Network providers such as principal-agent or joint venture. State of Maryland and UnitedHealthcare are not liable for any act or omission of any provider.

UnitedHealthcare is not considered to be an employer of the Plan Administrator for any purpose with respect to the administration or provision of benefits under this Plan.

State of Maryland and the Plan Administrator are solely responsible for:

- enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage);
- the timely payment of Benefits; and
- notifying you of the termination or modifications to the Plan.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient. Your provider is solely responsible for the quality of the services provided to you. You:

- are responsible for choosing your own provider;

- 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;
- are responsible for paying, directly to your provider, the cost of any non-Covered Health Service;
- must decide if any provider treating you is right for you (this includes In-Network providers you choose and providers to whom you have been referred); and
- must decide with your provider what care you should receive.

Interpretation of Benefits

State of Maryland and UnitedHealthcare have the sole and exclusive discretion to:

- interpret Benefits under the Plan;
- interpret the other terms, conditions, limitations and exclusions of the Plan, including this EOC and any Riders and/or Amendments; and
- make factual determinations related to the Plan and its Benefits.

State of Maryland and UnitedHealthcare may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan.

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

Information and Records

State of Maryland and UnitedHealthcare may use your individually identifiable health information to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. State of Maryland and UnitedHealthcare may request additional information from you to decide your claim for Benefits. State of Maryland and UnitedHealthcare will keep this information confidential. State of Maryland and UnitedHealthcare may also use your de-identified data for commercial purposes, including research, as permitted by law.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish State of Maryland and UnitedHealthcare with all information or copies of records relating to the services provided to you. State of Maryland and UnitedHealthcare 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 Employee's enrollment form. State of Maryland and UnitedHealthcare agree that such information and records will be considered confidential.

State of Maryland and UnitedHealthcare have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as State of Maryland is required to do by law or regulation. During and after the term of the Plan, State of Maryland and UnitedHealthcare and its related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your medical records or billing statements State of Maryland recommends 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 UnitedHealthcare, they also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, State of Maryland and UnitedHealthcare 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 does the Plan Administrator.

Incentives to Providers

In-Network providers may be provided financial incentives by UnitedHealthcare 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 In-Network providers are:

- bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness; or
- a practice called capitation which is when a group of In-Network providers receives a monthly payment from UnitedHealthcare for each Covered Person who selects an In-Network provider within the group to perform or coordinate certain health services. The In-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.

If you have any questions regarding financial incentives you may contact the telephone number on your ID card. You can ask whether your In-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. In addition, you may choose to discuss these financial incentives with your In-Network provider.

Incentives to You

Sometimes you may be offered coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but State of Maryland recommends that you

discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. You may call the number on the back of your ID card if you have any questions.

Rebates and Other Payments

State of Maryland and UnitedHealthcare may receive rebates for certain drugs that are administered to you 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 your Annual Deductible. State of Maryland and UnitedHealthcare do not pass these rebates on to you, nor are they applied to your Annual Deductible or taken into account in determining your Copays or Coinsurance.

Workers' Compensation Not Affected

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

Future of the Plan

Although the Group expects to continue the Plan indefinitely, it reserves the right to discontinue, alter or modify the Plan in whole or in part, at any time and for any reason, at its sole determination.

The Group's decision to terminate or amend a Plan may be due to changes in federal or state laws governing employee benefits, the requirements of the Internal Revenue Code or any other reason. A plan change may transfer plan assets and debts to another plan or split a plan into two or more parts. If the Group does change or terminate a plan, it may decide to set up a different plan providing similar or different benefits.

If this Plan is terminated, Covered Persons will not have the right to any other Benefits from the Plan, other than for those claims incurred prior to the date of termination, or as otherwise provided under the Plan. In addition, if the Plan is amended, Covered Persons may be subject to altered coverage and Benefits.

The amount and form of any final benefit you receive will depend on any Plan document or contract provisions affecting the Plan and Group decisions. After all Benefits have been paid and other requirements of the law have been met, certain remaining Plan assets will be turned over to the Group and others as may be required by any applicable law.

Plan Document

This Evidence of Coverage (EOC) represents an overview of your Benefits. In the event there is a discrepancy between the EOC and the official plan document, the plan document will govern. A copy of the plan document is available for your inspection during regular business hours in the office of the Plan Administrator. You (or your personal representative) may obtain a copy of this document by written request to the Plan Administrator, for a nominal charge.

SECTION 14 - GLOSSARY

What this section includes:
- Definitions of terms used throughout this EOC.

Many of the terms used throughout this EOC may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how Benefits are paid. This section defines terms used throughout this EOC, but it does not describe the Benefits provided by the Plan.

Addendum - any attached written description of additional or revised provisions to the Plan. The benefits and exclusions of this EOC and any amendments thereto shall apply to the Addendum except that in the case of any conflict between the Addendum and EOC and/or Amendments to the EOC, the Addendum shall be controlling.

Allowed Benefit - is a health care expense that is covered at least in part by the health benefit plan covering a member.

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; or
- rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health or Substance Use Disorder Services on an outpatient basis or inpatient basis (for example a Residential Treatment Facility).

Amendment - any attached written description of additional or alternative provisions to the Plan. Amendments are effective only when distributed by the Plan Sponsor or the Plan Administrator. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that the amendment is specifically changing.

Annual Deductible (or Deductible) - the amount you must pay for Covered Health Services in a calendar year before the Plan will begin paying Out-of-Network Benefits in that calendar year. The Deductible is shown in the first table in Section 5*, Plan Highlights*. Any amount you pay for medical expenses in the last three months of the previous calendar year, that is applied to the previous Deductible, will be carried over and applied to the current Deductible. This carry-over feature applies to the individual and family Deductible.

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:

- In vitro fertilization (IVF);
- Gamete intrafallopian transfer (GIFT);

- Pronuclear stage tubal transfer (PROST);
- Tubal embryo transfer (TET); and
- Zygote intrafallopian transfer (ZIFT).

Please note that Benefits are not available for GIFT and ZIFT procedures.

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

Bariatric Resource Services (BRS) - a program administered by UnitedHealthcare or its affiliates made available to you by State of Maryland. The BRS program provides:

- specialized clinical consulting services to Employees and enrolled Dependents to educate on obesity treatment options; and
- access to specialized In-Network facilities and Physicians for obesity surgery services.

Benefits - Plan payments for Covered Health Services, subject to the terms and conditions of the Plan and any Addendums and/or Amendments.

Body Mass Index (BMI) - 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.

BMI - see Body Mass Index (BMI).

Cancer Resource Services (CRS) - a program administered by UnitedHealthcare or its affiliates made available to you by State of Maryland. The CRS program provides:

- specialized consulting services, to Employees and enrolled Dependents with cancer;
- access to cancer centers with expertise in treating specific forms of cancer - even the most rare and complex conditions; and
- education to help patients understand their cancer and make informed decisions about their care and course of treatment.

Care Coordination - programs provided by the Claims Administrator that focus on prevention, education, and closing the gaps in care designed to encourage an efficient system of care for you and your covered Dependents.

Care Coordination Nurse - the primary nurse that UnitedHealthcare may assign to you if you have a chronic or complex health condition. If a Care Coordination Nurse is assigned to you, this nurse will call you to assess your progress and provide you with information and education.

CHD - see Congenital Heart Disease (CHD).

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.

Claims Administrator - UnitedHealthcare (also known as United Healthcare Services, Inc.) and its affiliates, who provide certain claim administration services for the Plan.

Clinical Trial - a scientific study designed to identify new health services that improve health outcomes. In a Clinical Trial, two or more treatments are compared to each other and the patient is not allowed to choose which treatment will be received.

COBRA - see Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Coinsurance - the percentage of Eligible Expenses you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works*.

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

Congenital Heart Disease (CHD) - any structural heart problem or abnormality that has been present since birth. Congenital heart defects may:

- be passed from a parent to a child (inherited);
- develop in the fetus of a woman who has an infection or is exposed to radiation or other toxic substances during her Pregnancy; or
- have no known cause.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) - a federal law that requires employers to offer continued health insurance coverage to certain employees and their dependents whose group health insurance has been terminated.

Copayment (or Copay) - the set dollar amount you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works*.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator. Reshaping a nose with a prominent bump is a good example of a Cosmetic Procedure because appearance would be improved, but there would be no improvement in function like breathing.

Cost-Effective - the least expensive equipment that performs the necessary function. This term applies to Durable Medical Equipment and prosthetic devices.

Covered Health Services - those health services, including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be:

- Medically Necessary;
- provided for the purpose of preventing, diagnosing or treating 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;
- included in Sections 5 and 6, *Plan Highlights* and *Additional Coverage Details* described as a Covered Health Service;
- provided to a Covered Person who meets the Plan's eligibility requirements, as described under *Eligibility* in Section 2, *Introduction*; and
- not identified in Section 8, *Exclusions*.

In applying the above definition, "scientific evidence" and "prevailing medical standards" 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; and
- "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.

The Claims Administrator maintains clinical protocols that describe the scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. You can access these clinical protocols (as revised from time to time) on **www.myuhc.com** or by calling the number on the back of your ID card. This information is available to Physicians and other health care professionals on UnitedHealthcareOnline.

Covered Person - either the Employee or an enrolled Dependent only while enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this EOC are references to a Covered Person.

CRS - see Cancer Resource Services (CRS).

Custodial Care - services that do not require special skills or training and that:

- provide assistance in activities of daily living (including but not limited to feeding, dressing, bathing, ostomy care, incontinence care, checking of routine vital signs, transferring and ambulating);
- are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence;
- do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the service is not changing; or
- do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Deductible - see Annual Deductible.

Dependent - an individual who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. A Dependent does not include anyone who is also enrolled as an Employee. No one can be a Dependent of more than one Employee.

Designated Facility - a facility that has entered into an agreement with the Claims Administrator or with an organization contracting on behalf of the Plan, to provide Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within your geographic area.

To be considered a Designated Facility, a facility must meet certain standards of excellence and have a proven track record of treating specific conditions.

Designated Virtual Network Provider - a provider or facility that has entered into an agreement with UnitedHealthcare, or with an organization contracting on UnitedHealthcare's behalf, to deliver Covered Health Services via interactive audio and video modalities.

DME - see Durable Medical Equipment (DME).

Domiciliary Care – living arrangements designed to meet the needs of people who cannot live independently but do not require Skilled Nursing Facility services.

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

- used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms;
- not disposable;

- not of use to a person in the absence of a Sickness, Injury or their symptoms;
- durable enough to withstand repeated use;
- not implantable within the body; and
- appropriate for use, and primarily used, within the home.

Eligible Expenses – for Covered Health Services, incurred while the Plan is in effect, Eligible Expenses are determined by UnitedHealthcare as stated below and as detailed in Section 3, *How the Plan Works*.

Eligible Expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines. UnitedHealthcare develops the reimbursement policy guidelines, in the UnitedHealthcare's 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 UnitedHealthcare accepts.

Employee - a full-time Employee of the State of Maryland who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. An Employee must live and/or work in the United States.

Employee Benefits Division – Division within the State of Maryland that administers the State of Maryland Employee and Retiree Health and Welfare Benefits Program.

Employer - State of Maryland.

EOB - see Explanation of Benefits (EOB).

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

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.

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

Exceptions:

- Clinical Trials for which Benefits are available as described under *Clinical Trials* in Section 6, *Additional Coverage Details*.
- If you are not a participant in a qualifying Clinical Trial as described under Section 6, *Additional Coverage Details*, and have a Sickness or condition that is likely to cause death within one year of the request for treatment, the Claims Administrator and State of Maryland may, at their discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, the Claims Administrator and State of Maryland must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Explanation of Benefits (EOB) - a statement provided by UnitedHealthcare to you, your Physician, or another health care professional that explains:

- the Benefits provided (if any);
- the allowable reimbursement amounts;
- Deductibles;
- Coinsurance;
- any other reductions taken;
- the net amount paid by the Plan; and
- the reason(s) why the service or supply was not covered by the Plan.

Gender Dysphoria (Gender Identity Disorder) - A disorder characterized by the following diagnostic criteria:

- a strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex);
- persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex;
- the disturbance is not concurrent with a physical intersex condition; and

- the disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

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

Group – State of Maryland.

Health Statement(s) - a single, integrated statement that summarizes EOB information by providing detailed content on account balances and claim activity.

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

Hospital - an institution, operated as required by law, which is:

- primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of sick or injured individuals. Care is provided through medical, mental health, substance use disorders, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians; and
- 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 Skilled Nursing Facility, convalescent home or similar institution.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

In-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 the Claims Administrator or with its affiliate to participate in the In-Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services. The Claims Administrator's affiliates are those entities affiliated with the Claims Administrator through common ownership or control with the Claims Administrator or with the Claims Administrator's 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 an In-Network provider for only some products. In this case, the provider will be an In-Network provider for the Covered Health Services and products included in the participation agreement, and an Out-of-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

In-Network Benefits - description of how Benefits are paid for Covered Health Services provided by In-Network provider. Refer to Section 5, *Plan Highlights* for details about how In-Network Benefits apply.

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

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

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

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

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

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

Kidney Resource Services (KRS) - a program administered by UnitedHealthcare or its affiliates made available to you by State of Maryland. The KRS program provides:

- specialized consulting services to Employees and enrolled Dependents with ESRD or chronic kidney disease;
- access to dialysis centers with expertise in treating kidney disease; and
- guidance for the patient on the prescribed plan of care.

Medicaid - a federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

Medical Emergency or Emergency Health Services - health care services that are provided in a Hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that 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 patient's health in jeopardy;
- serious impairment of bodily functions; or
- serious dysfunction of any bodily organ or part.

If a Primary Care Physician directs a Covered Person to the emergency room, the Plan pays the claim regardless of the diagnosis.

Medically Necessary – health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms, that are all of the following as determined by the Claims Administrator or its designee, within the Claims Administrator's sole discretion.

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

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

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

The Claims Administrator develops and maintains clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by the Claims Administrator and revised from time to time), are available to Covered Persons on **www.myuhc.com** or by calling the number on your ID card, and to Physicians and other health care professionals on www.unitedhealthcareonline.com**.**

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

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

Mental Health/Substance Use Disorder (MH/SUD) Administrator - the organization or individual designated by State of Maryland who provides or arranges Mental Health and Substance Use Disorder Services under the Plan.

Mental Illness - mental health or psychiatric diagnostic categories listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless they are listed in Section 8, *Exclusions*.

Open Enrollment - the period of time, determined by State of Maryland, during which eligible Employees may enroll themselves and their Dependents under the Plan. State of Maryland determines the period of time that is the Open Enrollment period.

Orthotics – devices that straighten or change the shape of a body part, including but not limited to cranial banding and some types of braces.

Out-of-Network – A provider of health care services that does not have a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with its affiliate to participate according to the same agreement of an In-Network provider.

For a description of how Benefits are paid for Covered Health Services provided by Out-of-Network providers. Refer to Section 5, *Plan Highlights* for details about how Out-of-Network Benefits apply.

Out-of-Network Benefits - description of how Benefits are paid for Covered Health Services provided by Out-of-Network providers. Refer to Section 5, *Plan Highlights* for details about how Out-of-Network Benefits apply.

Out-of-Pocket Maximum - the maximum amount you pay every calendar year. Refer to Section 5, *Plan Highlights* for the Out-of-Pocket Maximum amount. See Section 3, *How the Plan Works* for a description of how the Out-of-Pocket Maximum works.

Partial Hospitalization/Day Treatment - a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

Participant – a Participant of the Employer who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*.

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

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

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

Plan - The State of Maryland Medical Plan.

Plan Administrator - State of Maryland or its designee.

Plan Sponsor - State of Maryland.

Pregnancy - includes prenatal care, postnatal care, childbirth, and any complications associated with the 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.

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

Prior Authorization – UnitedHealthcare requires prior authorization for certain Covered Health Services. In general, Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. However, if you choose to receive Covered Health Services from an Out-of-Network provider, you are responsible for obtaining prior authorization before you receive the services. There are some Network Benefits, however, for which you are responsible for obtaining authorization before you receive the services.

Services for which prior authorization is required are identified in Section 4 *Care Coordination* and in Section 6, *Additional Coverage Details* within each Covered Health Service category.

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in a 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; or
- the service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on a home-care basis, whether the service is skilled or non-skilled independent nursing.

Reconstructive Procedure - a procedure performed to address a physical impairment where the expected outcome is restored or improved function. The primary purpose of a Reconstructive 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 changed or improved physical appearance. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure.

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

- it is established and operated in accordance with applicable state law for residential treatment programs;
- it provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance Use Disorder Administrator;
- it has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient; and
- it provides at least the following basic services in a 24-hour per day, structured milieu:
  - room and board;
  - evaluation and diagnosis;
  - counseling; and
  - referral and orientation to specialized community resources.

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

Retired Employee - an Employee who retires while covered under the Plan.

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.

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

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

- they are 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;
- a Physician orders them;

- they 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;
- they require clinical training in order to be delivered safely and effectively; and
- they are not Custodial Care, as defined in this section.

Skilled Nursing Facility - a nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility that is part of a Hospital is considered a Skilled Nursing Facility for purposes of the Plan.

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.

Spouse - an individual to whom you are legally married.

State of Maryland Wellness Program - a program administered by UnitedHealthcare or its affiliates made available to you by State of Maryland. The State of Maryland Wellness Program provides Employees and their Spouses the opportunity to earn points toward enhanced benefits such as waiving copays for all Primary Care Physician (PCP) visits in the next calendar year by completing certain biometric testing or other identified activities in the current calendar year.

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

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

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

UnitedHealth Premium Program℠ - a program that identifies In-Network Physicians or facilities that have been designated as a UnitedHealth Premium Program℠ Physician or facility for certain medical conditions.

To be designated as a UnitedHealth Premium℠ provider, Physicians and facilities must meet program criteria. The fact that a Physician or facility is an In-Network Physician or facility does not mean that it is a UnitedHealth Premium Program℠ Physician or facility.

Unproven Services - health 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 are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received.
- Well-conducted cohort studies from more than one institution are studies in which 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.

UnitedHealthcare has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, UnitedHealthcare issues 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), UnitedHealthcare and State of Maryland may, at their discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, UnitedHealthcare and State of Maryland 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.

The decision about whether such a service can be deemed a Covered Health Service is solely at UnitedHealthcare and State of Maryland's discretion. Other apparently similar promising but unproven services may not qualify.

Urgent Care - treatment of an unexpected Sickness or Injury that is not life-threatening but requires outpatient medical care that cannot be postponed. An urgent situation requires prompt medical attention to avoid complications and unnecessary suffering, such as high fever, a skin rash, or an ear infection.

Urgent Care Center - a facility that provides Urgent Care services, as previously defined in this section. In general, Urgent Care Centers:

- do not require an appointment;
- are open outside of normal business hours, so you can get medical attention for minor illnesses that occur at night or on weekends; and
- provide an alternative if you need immediate medical attention, but your Physician cannot see you right away.

SECTION 15 - IMPORTANT ADMINISTRATIVE INFORMATION

What this section includes:
- Plan administrative information.

This section includes information on the administration of the medical Plan. While you may not need this information for your day-to-day participation, it is information you may find important.

Additional Plan Description

Claims Administrator: The company which provides certain administrative services for the Plan Benefits described in this Evidence of Coverage.

United Healthcare Services, Inc.
9900 Bren Road East
Minnetonka, MN 55343

The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of benefits under the Plan Sponsor's Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

Type of Administration of the Plan: The Plan Sponsor provides certain administrative services in connection with its Plan. The Plan Sponsor may, from time to time in its sole discretion, contract with outside parties to arrange for the provision of other administrative services including arrangement of access to an In-Network Provider; claims processing services, including coordination of benefits and subrogation; utilization management and complaint resolution assistance. This external administrator is referred to as the Claims Administrator. For Benefits as described in this Evidence of Coverage, the Plan Sponsor also has selected a provider network established by UnitedHealthcare Insurance Company . The named fiduciary of Plan is State of Maryland, the Plan Sponsor.

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

ATTACHMENT I - HEALTH CARE REFORM NOTICES

Patient Protection and Affordable Care Act ("PPACA")

Patient Protection Notices

The Claims Administrator generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Claims Administrator's network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator at the number on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Claims Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Claims Administrator at the number on the back of your ID card.

ATTACHMENT II - LEGAL NOTICES

Women's Health and Cancer Rights Act of 1998

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

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

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

The amount you must pay for such Covered Health Services (including Copayments and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

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

Under Federal law, group health Plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain prior authorization or notify the Claims Administrator. For information on notification or prior authorization, contact your issuer.

ADDENDUM - UNITEDHEALTH ALLIES

Introduction

This Addendum to the Evidence of Coverage provides discounts for select non-Covered Health Services from Physicians and health care professionals.

When the words "you" and "your" are used the Plan is referring to people who are Covered Persons as the term is defined in the Evidence of Coverage (EOC). See Section 14, *Glossary* in the EOC.

Important:
UnitedHealth Allies is not a health insurance plan. You are responsible for the full cost of any services purchased, minus the applicable discount. Always use your health insurance plan for Covered Health Services described in the Evidence of Coverage (see Section 5, *Plan Highlights*) when a benefit is available.

What is UnitedHealth Allies?

UnitedHealth Allies is a health value program that offers savings on certain products and services that are not Covered Health Services under your health plan.

Because this is not a health insurance plan, you are not required to receive a referral or submit any claim forms.

Discounts through UnitedHealth Allies are available to you and your Dependents as defined in the Evidence of Coverage in Section 14, *Glossary*.

Selecting a Discounted Product or Service

A list of available discounted products or services can be viewed online at **www.healthallies.com** or by calling the number on the back of your ID card.

After selecting a health care professional and product or service, reserve the preferred rate and print the rate confirmation letter. If you have reserved a product or service with a customer service representative, the rate confirmation letter will be faxed or mailed to you.

Important:
You must present the rate confirmation at the time of receiving the product or service in order to receive the discount.

Visiting Your Selected Health Care Professional

After reserving a preferred rate, make an appointment directly with the health care professional. Your appointment must be within ninety (90) days of the date on your rate confirmation letter.

Present the rate confirmation and your ID card at the time you receive the service. You will be required to pay the preferred rate directly to the health care professional at the time the service is received.

Additional UnitedHealth Allies Information

Additional information on the UnitedHealth Allies program can be obtained online at **www.healthallies.com** or by calling the toll-free phone number on the back of your ID card.

ADDENDUM - PARENTSTEPS®

Introduction

This Addendum to the Evidence of Coverage illustrates the benefits you are eligible for under the ParentSteps program.

When the words "you" and "your" are used the Plan is referring to people who are Covered Persons as the term is defined in the Evidence of Coverage (EOC). See Section 14, *Glossary* in the EOC.

Important:
ParentSteps is not a health insurance plan. You are responsible for the full cost of any services purchased. ParentSteps will collect the provider payment from you online via the ParentSteps website and forward the payment to the provider on your behalf. Always use your health insurance plan for Covered Health Services described in the Evidence of Coverage 5, *Plan Highlights*) when a benefit is available.

What is ParentSteps?

ParentSteps is a discount program that offers savings on certain medications and services for the treatment of infertility that are not Covered Health Services under your health plan.

This program also offers:

- guidance to help you make informed decisions on where to receive care;
- education and support resources through experienced infertility nurses;
- access to providers contracted with UnitedHealthcare that offer discounts for infertility medical services; and
- discounts on select medications when filled through a designated pharmacy partner.

Because this is not a health insurance plan, you are not required to receive a referral or submit any claim forms.

Discounts through this program are available to you and your Dependents. Dependents are defined in the Evidence of Coverage in Section 14, *Glossary*.

Registering for ParentSteps

Prior to obtaining discounts on infertility medical treatment or speaking with an infertility nurse you need to register for the program online at www.myoptumhealthparentsteps.com or by calling ParentSteps toll-free at 1-877-801-3507.

Selecting a Contracted Provider

After registering for the program you can view ParentSteps facilities and clinics online based on location, compare IVF cycle outcome data for each participating provider and see the specific rates negotiated by ParentSteps with each provider for select types of infertility treatment in order to make an informed decision.

Visiting Your Selected Health Care Professional

Once you have selected a provider, you will be asked to choose that clinic for a consultation. You should then call and make an appointment with that clinic and mention you are a ParentSteps member. ParentSteps will validate your choice and send a validation email to you and the clinic.

Obtaining a Discount

If you and your provider choose a treatment in which ParentSteps discounts apply, the provider will enter in your proposed course of treatment. ParentSteps will alert you, via email, that treatment has been assigned. Once you log in to the ParentSteps website, you will see your treatment plan with a cost breakdown for your review.

After reviewing the treatment plan and determining it is correct you can pay for the treatment online. Once this payment has been made successfully ParentSteps will notify your provider with a statement saying that treatments may begin.

Speaking with a Nurse

Once you have successfully registered for the ParentSteps program you may receive additional educational and support resources through an experienced infertility nurse. You may even work with a single nurse throughout your treatment if you choose.

For questions about diagnosis, treatment options, your plan of care or general support, please contact a ParentSteps nurse via phone (toll-free) by calling 1-866-774-4626.

ParentSteps nurses are available from 8 a.m. to 5 p.m. Central Time; Monday through Friday, excluding holidays.

Additional ParentSteps Information

Additional information on the ParentSteps program can be obtained online at www.myoptumhealthparentsteps.com or by calling 1-877-801-3507 (toll-free).