Evidence of Coverage

State of Maryland
Choice Plus PPO Plan

Effective: January 1, 2021 through December 31, 2021
Group Number: 716450

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SECTION 1 - WELCOME

Quick Reference Box

- Member services, claim inquiries, Care Coordination and Mental Health/Substance - Related and Addictive Disorders 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-Related and Addictive Disorders, 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 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 child who is under age 26, including a biological child, stepchild, a legally adopted child or a child placed for adoption.
- your grandchild, legal ward or other child relative that is unmarried, living with the employee/retiree and is a tax dependent of the employee/retiree, may be covered thru end of month he/she turns 25;
- an unmarried child, stepchild or adopted child age 26 or over who became **permanently** disabled prior to the child reaching age 26 and is dependent upon you. Subsequently, all certifications are lifetime and there is no need for re-certification every two years;
- an unmarried grandchild, legal ward or other child relative, living with the employee/retiree and is a tax dependent of the employee/retiree, who became **permanently** disabled prior to turning age 25 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 the first of the month following the event. 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 of the month, 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 birth, adoption or placement for adoption is effective the date of the family status change, 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 Plan is a voluntary Wellness Program that is available to all State employees, non-Medicare eligible retirees and enrolled spouses (children are not eligible to participate, regardless of age). If you choose to participate in the Wellness Program the eligible participants will be asked to complete wellness activities throughout the 2021 calendar year. Once these activities are completed, enrollees will enjoy enhanced benefits such as waiving copays for all Primary Care Physician (PCP) visits and/or a $5 reduction on Specialist copays by completing age/gender appropriate preventive screenings recommended by your PCP. A list of recommended screenings can be found on the State of Maryland website http://dbm.maryland.gov/benefits/Pages/WellnessHome.aspx and in Section 7, *State of Maryland Wellness Program*.

Once you who have completed any of the wellness activities, you will be transferred to a new Plan which will give you the enhanced benefits on your completions. Listed below are the Plans and their rewards:

The Choice Plus Plan, this Plan is where all copays apply, as listed on page 22.

The Choice Plus - No PCP Copay Plan, this Plan is where you have completed Steps 1 and 2 from the 2021 Healthy Activities chart on page 9 and all PCP copays are waived.

The Choice Plus - Lower Specialist Copay Plan, this Plan is once you have completed Step 3 of the Healthy Activities chart on page 9 and you will receive the reduction in the Specialist copay from $30 to $25.

The Choice Plus - No PCP Copay Lower Specialist Plan, this Plan indicates that you have completed all the Healthy Activities and you will receive your PCP copays waived and the reduction in the Specialist copay to $25.

2021 HEALTHY ACTIVITIES - January 1, 2021 - December 31, 2021

1. Select a primary care provider (PCP). You can let us know if you have selected a PCP by logging into Rally℠ and go to "Rally for Health Rewards". Confirm your PCP at the bottom of the page.
2. Complete Health Assessment – You have two options to choose from on **www.uhcmaryland.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 Department of Budget and Management's website.
3. Complete age/gender appropriate preventative screenings recommended by your PCP. A list of recommended screenings can be found on the State of Maryland website http://dbm.maryland.gov/benefits/Pages/WellnessHome.aspx and in Section 7, *State of Maryland Wellness Program*.

Get Rewarded!

Upon completion of Step 1 & 2 of your Wellness Activities, you and/or your spouse will have your PCP copays waived.

Upon completion of Step 3 of your Wellness Activities you and/or your spouse can also earn a $5 reduction on Specialist copays.

* 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 EOC.

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 negotiated by UnitedHealthcare or an amount permitted 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 applies based on the claim type:

  ♦ 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 freestanding laboratory service.
  - 45% of *CMS* for the same or similar durable medical equipment from a freestanding supplier, 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 or the amount typically accepted by a provider for the same or similar service location and resources of the service. The relative value scale may be based on the difficulty, time, work, risk, location 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.*

In-Network Benefits	Out-of-Network Benefits
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. As of the publication of this EOC, the Care Coordination^{SM} program includes:

- **Admission counseling** - Nurse Advocates are available to help you prepare for a successful surgical admission and recovery. Call the number on your ID card for support.
- **Inpatient care management** - If you are hospitalized, a Care Coordination^{SM} nurse will work with your Physician to make sure you are getting the care you need and that your Physician's treatment plan is being carried out effectively.
- **Readmission Management** - This program serves as a bridge between the Hospital and your home if you are at high risk of being readmitted. After leaving the Hospital, if you have a certain chronic or complex condition, you may receive a phone call from a Care Coordination^{SM} nurse to confirm that medications, needed equipment, or follow-up services are in place. The nurse will also share important health care information, reiterate and reinforce discharge instructions, and support a safe transition home.

- **Risk Management** - Designed for participants with certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies. Participants may receive a phone call from a Care Coordination[SM] nurse to discuss and share important health care information related to the participant's specific chronic or complex condition.

If you do not receive a call from a Care Coordination[SM] nurse but feel you could benefit from any of these programs, please call the number on your ID card.

Prior Authorization

UnitedHealthcare requires prior authorization for certain Covered Health Services. In-Network Primary Physicians and other In-Network providers are responsible for obtaining prior authorization before they provide these services to you.

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 number on 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 number on 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.

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 due to age or disability, 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
■ Virtual Visits	$15 copay	Not Applicable
■ 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
Coupons: The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible.		

Plan Features	In-Network	Out-of-Network
Annual Coinsurance Out-of-Pocket Maximum[2,5]		
■ Individual	$1,000	$3,000
■ Family (not to exceed the applicable Individual amount per Covered Person)	$2,000	$6,000
Annual Copayment Out-of-Pocket Maximum[3,5]		
■ Individual Copay Maximum	$1,000	N/A
■ Family Copay Maximum	$2,000	N/A
Total Medical Out-of-Pocket Maximum[5]		
■ 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-related and addictive disorders 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.

[5]**Coupons:** The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Out-of-Pocket Maximum.

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.	100% of the allowed benefit	70% of allowed benefit after you meet the Annual Deductible
Amino Acid-Based Elemental Formula	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**
Cellular and Gene Therapy Services must be received at a Designated Provider.	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.	Out-of-Network Benefits are not available
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	90% of the allowed benefit	70% of the allowed benefit after you meet the Annual Deductible
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.	

Covered Health Services[1] See page 33 for explanation	Percentage of Eligible Expenses Payable by the Plan:	
	In-Network	**Out-of-Network**
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)		
■ Purchase or rental of 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
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

Covered Health Services[1] See page 33 for explanation	Percentage of Eligible Expenses Payable by the Plan:	
	In-Network	**Out-of-Network**
■ 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
Gender Dysphoria	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 and in your separate prescription drug coverage.	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 and in your separate prescription drug coverage.
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
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

Covered Health Services[1] See page 33 for explanation	Percentage of Eligible Expenses Payable by the Plan:	
	In-Network	**Out-of-Network**
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
Lab, X-Ray and Diagnostics - Outpatient	90% of the allowed benefit Lab and x-ray services related to PSA screenings, 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

Covered Health Services[1] See page 33 for explanation	Percentage of Eligible Expenses Payable by the Plan:	
	In-Network	**Out-of-Network**
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
Mental Health Services		
■ Inpatient	90% of the allowed benefit	70% of the allowed benefit after you meet the Annual Deductible
■ Outpatient	100% of the allowed benefit after you pay a Copayment of $15 per visit	70% of the allowed benefit after you meet the Annual Deductible
	90% of the allowed benefit for Partial Hospitalization/ Intensive Outpatient Treatment	70% of the allowed benefit for Partial Hospitalization/ Intensive Outpatient Treatment after you meet the Annual Deductible
Neurobiological Disorders - Autism Spectrum Disorder Services		
■ Inpatient	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**
■ Outpatient	100% of the allowed benefit after you pay a Copayment of $15 per visit 90% of the allowed benefit for Partial Hospitalization/ Intensive Outpatient Treatment	70% of the allowed benefit after you meet the Annual Deductible 70% of the allowed benefit for Partial Hospitalization/ Intensive Outpatient Treatment after you meet the Annual Deductible
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 Provider 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.	

Covered Health Services[1] See page 33 for explanation	Percentage of Eligible Expenses Payable by the Plan:	
	In-Network	**Out-of-Network**
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
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 colonoscopy and cervical 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

Covered Health Services[1] See page 33 for explanation	Percentage of Eligible Expenses Payable by the Plan:	
	In-Network	**Out-of-Network**
■ Mammogram	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
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

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	Deductible 70% of the allowed benefit after you meet the Annual Deductible
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
■ Post-cochlear implant aural therapy	100% of the allowed benefit after a $15 Primary Care Physician Copay or a $30 Specialist 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		
■ Skilled Nursing Facility	90% of allowed benefit	70% of allowed benefit after you meet the Annual Deductible
■ Acute Inpatient Rehabilitation Facility See Section 6, *Additional Coverage Details*, for limits.	90% of 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**
Substance-Related and Addictive Disorders Services		
■ Inpatient	90% of the allowed benefit	70% of the allowed benefit after you meet the Annual Deductible
■ Outpatient	100% of the allowed benefit after you pay a Copayment of $15 per visit	70% of the allowed benefit after you meet the Annual Deductible
	90% of the allowed benefit for Partial Hospitalization/ Intensive Outpatient Treatment	70% of the allowed benefit for Partial Hospitalization/ Intensive Outpatient Treatment after you meet the Annual Deductible
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

Covered Health Services[1] See page 33 for explanation	Percentage of Eligible Expenses Payable by the Plan:	
	In-Network	**Out-of-Network**
Transplantation Services Transplantation services including evaluation for transplant, organ procurement and donor searches and transplantation procedures may be received by a Designated Provider, In-Network Provider or Out-of-Network Provider and all are considered at the In-Network Benefit level.	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.	
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
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 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

Covered Health Services[1] See page 33 for explanation	**Percentage of Eligible Expenses Payable by the Plan:**	
	In-Network	**Out-of-Network**
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]Please obtain prior authorization before receiving Covered Health Services, as described in Section 6, *Additional Coverage Details*.

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 ambulance transportation. For Out-of-Network Benefits, if you are requesting non-Emergency air ambulance services, (including any affiliated non-Emergency ground ambulance transport in conjunction with non-Emergency air ambulance transport), you must obtain prior authorization as soon as possible before transport. If you fail to obtain prior authorization from the Claims administrator, Benefits will be reduced to 50% of Eligible Expenses. This 50% penalty does not apply toward the Out-of-Pocket Maximum.

For In-Network Benefits it is the participating provider's responsibility to obtain authorization.

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;
- Eosinophilic disorders (as evidenced by results of a biopsy); and
- Impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length and motility of the gastrointestinal tract.

Cellular and Gene Therapy

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

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

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
For Out-of-Network Benefits you must obtain prior authorization as soon as the possibility of participation in a Clinical Trial arises. If you do not obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses. This 50% penalty does not apply toward the Out-of-Pocket Maximum.

For In-Network Benefits it is the participating provider's responsibility to obtain authorization.

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 UnitedHealthcare at the number on your ID card for information about these guidelines.

The Plan pays Benefits for CHD services ordered by a Physician and received at a facility participating in the CHD Resource Services program. Benefits include the facility charge and the charge for supplies and equipment. Benefits for Physician services are described under *Physician Fees for Surgical and Medical Services.*

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

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).

- Approved fetal interventions.

CHD services other than those listed above are excluded from coverage, unless determined by the Claims Administrator to be proven procedures for the involved diagnoses. Contact CHD Resource Services at 1-888-936-7246 before receiving care for information about CHD services. More information is also available at **www.myoptumhealthcomplexmedical.com**.

If you receive CHD services from a facility that is not a Designated Provider, 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 CHD program, you must contact CHD Resource Services at 1-888-936-7246 prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CHD program if CHD provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

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 do not obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses. This 50% penalty does not apply toward the Out-of-Pocket Maximum.

For In-Network Benefits it is the participating provider's responsibility to obtain authorization.

It is important that you notify the Claims Administrator 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.

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 three months of the accident, or if not a Covered Person at the time of the accident, within the first three months of coverage under the Plan, 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, or if not a Covered Person at the time of the accident, within the first 12 months of coverage under the Plan.

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

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

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

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

Diabetic Self-Management Items

Insulin pumps and supplies that are not fully implanted into the body for the management and treatment of diabetes, based upon your medical needs include:

- insulin pumps that are subject to all the conditions of coverage stated under Durable Medical Equipment (DME);
- blood glucose meters including continuous 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.

Prior Authorization Requirement
For Out-of-Network Benefits you must obtain prior authorization from the Claims Administrator 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. This 50% penalty does not apply toward the Out-of-Pocket Maximum.

For In-Network Benefits it is the participating provider's responsibility to obtain authorization.

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
- purchase or rental of breast pumps & breast pump supplies.

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

Benefits also include dedicated speech generating 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 these devices are available only after completing a required three-month rental period.

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

Benefits for dedicated speech generating 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.

Prior Authorization Requirements
For Out-of-Network Benefits you must obtain prior authorization from the Claims Administrator 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. This 50% penalty does not apply toward the Out-of-Pocket Maximum.

For In-Network Benefits it is the participating provider's responsibility to obtain authorization.

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 two business days 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.

Note: If you are confined in an Out-of-Network Hospital after you receive outpatient Emergency Health Services, you must notify the Claims Administrator within two business days or on the same day of admission if reasonably possible. The Claims Administrator may elect to transfer you to an In-Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the Out-of-Network Hospital after the date the Claims Administrator decides a transfer is medically appropriate, In-Network Benefits will not be provided. Out-of-Network Benefits may be available if the continued stay is determined to be a Covered Health Service.

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.

Gender Dysphoria

Benefits for the treatment of Gender Dysphoria limited to the following services:

- **Psychotherapy** for Gender Dysphoria and associated co-morbid psychiatric diagnoses as described under Mental Health Services in this section.
- Cross-sex hormone therapy:
  - Cross-sex hormone therapy administered by a medical provider (for example during an office visit) is provided as described under *Pharmaceutical Products – Outpatient* in the section.
  - Cross-sex hormone therapy dispensed from a pharmacy is provided as described under your separate prescription drug coverage.
- Puberty suppressing medication injected or implanted by a medical provider in a clinical setting.
- Laboratory testing to monitor the safety of continuous cross-sex hormone therapy.
- Surgery for the treatment for Gender Dysphoria, including the surgeries listed below:

  Male to Female:

  - Clitoroplasty (creation of clitoris)
  - Labiaplasty (creation of labia)
  - Orchiectomy (removal of testicles)
  - Penectomy (removal of penis)
  - Urethroplasty (reconstruction of female urethra)

- Vaginoplasty (creation of vagina)

Female to Male:

- Bilateral mastectomy or breast reduction
- Hysterectomy (removal of uterus)
- Metoidioplasty (creation of penis, using clitoris)
- Penile prosthesis
- Phalloplasty (creation of penis)
- Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
- Scrotoplasty (creation of scrotum)
- Testicular prosthesis
- Urethroplasty (reconstruction of male urethra)
- Vaginectomy (removal of vagina)
- Vulvectomy (removal of vulva)

Genital Surgery and Bilateral Mastectomy or Breast Reduction Surgery Documentation Requirements:

The Covered Person must provide documentation of the following for breast surgery:

- A written psychological assessment from at least one qualified behavioral health provider experienced in treating Gender Dysphoria. The assessment must document that the Covered Person meets all of the following criteria:
  - Persistent, well-documented Gender Dysphoria.
  - Capacity to make a fully informed decision and to consent for treatment.
  - Must be 18 years or older.
  - If significant medical or mental health concerns are present, they must be reasonably well controlled.

The Covered Person must provide documentation of the following for genital surgery:

- A written psychological assessment from at least two qualified behavioral health providers experienced in treating Gender Dysphoria, who have independently assessed the Covered Person. The assessment must document that the Covered Person meets all of the following criteria:
  - Persistent, well-documented Gender Dysphoria.
  - Capacity to make a fully informed decision and to consent for treatment.
  - Must 18 years or older.
  - If significant medical or mental health concerns are present, they must be reasonably well controlled.
  - Complete at least 12 months of successful continuous full-time real-life experience in the desired gender.
  - Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated).

The treatment plan is based on identifiable external sources including the *World Professional Association for Transgender Health (WPATH)* standards, and/or evidence-based professional society guidance.

Prior Authorization Requirement for Surgical Treatment:
For Out-of-Network Benefits you must obtain prior authorization as soon as the possibility of surgery arises. If you do not obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses. This 50% penalty does not apply toward the Out-of-Pocket Maximum. In addition, for Out-of-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

It is important that you notify the Claims Administrator as soon as the possibility of surgery arises. Your notification allows the opportunity for the Claims Administrator to provide you with additional information and services that may be available to you and are designed to achieve the best outcomes for you.

Prior Authorization Requirement for Non-Surgical Treatment:
Depending upon where the Covered Health Service is provided, any applicable prior authorization requirements will be the same as those stated under each Covered Health Service category.

For In-Network Benefits it is the participating provider's responsibility to obtain authorization.

Hearing Care and Hearing Aids

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

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

If more than one type of hearing aid can meet your functional needs, Benefits are available only for the hearing aid that meets the minimum specifications for your needs. If you purchase a hearing aid that exceeds these minimum specifications, the Plan will pay only the amount that the Plan would have paid for the hearing aid that meets the minimum specifications, and you will be responsible for paying any difference in cost.

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

- craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or
- hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

Benefits are available for a basic model hearing aid (behind the ear) only and for charges for associated fitting and testing that is purchased as a result of a written recommendation by a licensed audiologist. 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.

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.

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

Benefits for hearing aids are limited to a single purchase (including repair/replacement) per hearing impaired ear every 36 months.

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 you must obtain prior authorization from the Claims Administrator five business days before receiving services including nutritional foods and Private Duty Nursing 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. This 50% penalty does not apply toward the Out-of-Pocket Maximum.

For In-Network Benefits it is the participating provider's responsibility to obtain authorization.

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 from the Claims Administrator 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. This 50% penalty does not apply toward the Out-of-Pocket Maximum. In addition, for Out-of-Network Benefits, you must contact the Claims Administrator within 24 hours of admission for an Inpatient Stay in a hospice facility.

For In-Network Benefits it is the participating provider's responsibility to obtain authorization.

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
For Out-of-Network Benefits for:

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

If you fail to obtain prior authorization from or provide notification to the Claims Administrator as required, Benefits will be reduced to 50% of Eligible Expenses. This 50% penalty does not apply toward the Out-of-Pocket Maximum. In addition, for Out-of-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

For In-Network Benefits it is the participating provider's responsibility to obtain authorization.

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 for a **married Member** are available when:

1) For a married 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 married 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 one (1) year of unprotected vaginal intercourse failing to result in pregnancy; or

b) If the Member and the Member's Spouse are of the same sex, three (3) attempts of artificial insemination over the course of one (1) year failing to result in pregnancy; or

3) The infertility of the married Member or Member's Spouse 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.

b. Benefits for an **unmarried Member** are available when:

1) The unmarried Member has had three attempts of artificial insemination over the course of one year failing to result in pregnancy; or

2) The infertility of the unmarried Member 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.

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

d. 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.

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

Any combination of In-Network Benefits and Out-of-Network Benefits is limited to 18 Presumptive Drug Tests and 18 Definitive Drug Tests per calendar year.

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 Genetic Testing and sleep studies, you must obtain prior authorization from the Claims Administrator 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. This 50% penalty does not apply toward the Out-of-Pocket Maximum.

For In-Network Benefits it is the participating provider's responsibility to obtain authorization.

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 under Physician Fees for Surgical and Medical Services.)

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. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

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

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family and group therapy.
- Provider-based case management services.
- Crisis intervention.
- Biofeedback Therapy.

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

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Prior Authorization Requirement
For Out-of-Network Benefits for:

- A scheduled admission for Mental Health Services (including an admission for services at a Residential Treatment facility) you must obtain prior authorization from the Claims Administrator five business days before admission.
- A non-scheduled admission (including Emergency admissions) you must provide notification as soon as is reasonably possible.

In addition, for Out-of-Network Benefits you must obtain prior authorization from the Claims Administrator before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits, with or without medication management. If you fail to obtain prior authorization from or provide notification to the Claims Administrator as required, Benefits will be reduced to 50% of Eligible Expenses. This 50% penalty does not apply toward the Out-of-Pocket Maximum.

For In-Network Benefits it is the participating provider's responsibility to obtain authorization.

Neurobiological Disorders - Autism Spectrum Disorder Services

The Plan pays Benefits for behavioral services for Autism Spectrum Disorder including Intensive Behavioral Therapies such as Applied Behavior Analysis (ABA) that are the following:

- Focused on the treatment of core deficits of Autism Spectrum Disorder.
- Provided by a Board Certified Applied Behavior Analyst (BCBA) or other qualified provider under the appropriate supervision.
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning.

These Benefits describe only the behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Service for which Benefits are available under the applicable medical Covered Health Services categories as described in this section.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

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

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures;
- Medication management and other associated treatments.
- Individual, family and group therapy.
- Provider-based case management services.
- Crisis intervention.
- Biofeedback Therapy.

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

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders 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 services at a Residential Treatment facility), you must obtain authorization from the Claims Administrator five business days before admission.
- A non-scheduled admission (including Emergency admissions) you must provide notification as soon as is reasonably possible.

In addition, for Out-of-Network Benefits you must obtain prior authorization from the Claims Administrator before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits, with or without medication management; Intensive Behavioral Therapy, including *Applied Behavior Analysis (ABA)*. If you fail to obtain prior authorization from or provide notification to the Claims Administrator as required, Benefits will be reduced to 50% of Eligible Expenses. This 50% penalty does not apply toward the Out-of-Pocket Maximum.

For In-Network Benefits it is the participating provider's responsibility to obtain authorization.

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 Providers 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 do not obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses. This 50% penalty does not apply toward the Out-of-Pocket Maximum. In addition, for Out-of-Network Benefits you must contact the Claims Administrator 24 hours before admission for an Inpatient Stay.

It is important that you notify the Claims Administrator 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.

For In-Network Benefits it is the participating provider's responsibility to obtain authorization.

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. Depending on where the Pharmaceutical Product is administered, Benefits will be provided for administration of the Pharmaceutical Product under the corresponding Benefit category

in this SPD. Benefits under this section do not include medications for the treatment of infertility.

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

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

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

UnitedHealthcare may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at **www.myuhc.com** or by calling the number on your ID card.

Benefits are provided for Medically Necessary diagnosis, evaluation, and treatment of autoimmune encephalitis, pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute onset neuropsychiatric syndrome, including the use of intravenous immunoglobulin therapy.

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.

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 from the Claims Administrator 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. This 50% penalty does not apply toward the Out-of-Pocket Maximum.

For In-Network Benefits it is the participating provider's responsibility to obtain authorization.

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, *Clinical Programs and Resources*, 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. Benefits for PSA screenings that do not have in effect a rating of "A" or "B" are described under *Lab, X-Ray and Diagnostics – Outpatient*;
- 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; ■ 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;

Covered Preventive Care Services	
	■ HPV injections for boys and girls; and ■ No limit for flu vaccines under the age of eight (8). (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	■ screening colonoscopy or sigmoidoscopy and other colorectal cancer screening tests in accordance with the latest screening guidelines issued by the *American Cancer Society;* ■ 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 ■ 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 radio isotopic 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

Covered Preventive Care Services	
	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 vertebral bodies and are a candidate for therapeutic intervention or for an extensive diagnostic evaluation for metabolic bone disease; or - you are receiving long-term glucocorticoid (steroid) therapy; - 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; ■ purchase or rental of breast pumps and breast pump supplies (In-Network only); ■ counseling for sexually transmitted infections (In-Network only); ■ counseling and screening for human immune deficiency virus (HIV); ■ screening and counseling for interpersonal and domestic violence; ■ screening for gestational diabetes; ■ 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*.

Covered Preventive Care Services	
	"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 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). No limit for flu vaccines under the age of eight (8).

For questions about your preventive care Benefits under this Plan call the number on 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.

Prior Authorization Requirements
For Out-of-Network Benefits you must obtain prior authorization from the Claims Administrator 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. This 50% penalty does not apply toward the Out-of-Pocket Maximum.

For In-Network Benefits it is the participating provider's responsibility to obtain authorization.

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 Reconstructive Procedure, you must obtain prior authorization from the Claims Administrator five business days before a scheduled Reconstructive Procedure is performed;
- a non-scheduled Reconstructive Procedure, you must provide notification within one business day or as soon as is reasonably possible.

If you fail to obtain prior authorization from or provide notification to the Claims Administrator as required, Benefits will be reduced to 50% of Eligible Expenses. This 50% penalty does not apply toward the Out-of-Pocket Maximum. In addition, for Out-of-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

For In-Network Benefits it is the participating provider's responsibility to obtain authorization.

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;
- cognitive rehabilitation therapy following a post-traumatic brain Injury or cerebral vascular accident;
- 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 under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Rehabilitative services provided in a Covered Person's home by a Home Health Agency are provided as described under Home Health Care. Rehabilitative services provided in a Covered Person's home other than by a Home Health Agency are provided as described under this section.

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

For the purpose of this Benefit, "habilitative services" means Medically Necessary skilled health care services that help a person keep, learn or improve skills and functioning for daily living. Habilitative services are skilled when all of the following are true:

- The services are part of a prescribed plan of treatment or maintenance program that is Medically Necessary to maintain a Covered Person's current condition or to prevent or slow further decline.
- It is ordered by a Physician and provided and administered by a licensed provider.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

The Claims Administrator will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition are not considered habilitative services. A service will not be determined to be "skilled" simply because there is not an available caregiver.

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 or Physician.
- 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.

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 or Congenital Anomaly. The Plan will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or stroke.

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, cognitive rehabilitation therapy and speech therapy combined; and
- 20 visits per calendar year for pulmonary rehabilitation therapy.

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 from the Claims Administrator 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. This 50% penalty does not apply toward the Out-of-Pocket Maximum.

For In-Network Benefits it is the participating provider's responsibility to obtain authorization.

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:

- Inpatient Rehabilitation at an Out-of-Network facility is payable ONLY when services are rendered at a Skilled Nursing Facility.
- Out-of-Network Benefits for Inpatient Rehabilitation in a Hospital or Rehabilitation Center are NOT COVERED.
- 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-scheduled admission (or admissions resulting from an Emergency) you must provide notification as soon as is reasonably possible.

If you fail to obtain prior authorization from or provide notification to the Claims Administrator as required, Benefits will be reduced to 50% of Eligible Expenses. This 50% penalty does not apply toward the Out-of-Pocket Maximum. In addition, for Out-of-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

For In-Network Benefits it is the participating provider's responsibility to obtain authorization.

Substance-Related and Addictive Disorders Services

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. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

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

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family and group therapy.
- Provider-based case management services.
- Crisis intervention;
- Methadone Treatment.

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

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Prior Authorization Requirement
For Out-of-Network Benefits for:

- A scheduled admission for Substance-Related and Addictive Disorders Services (including an admission for services at a Residential Treatment facility), you must obtain authorization from the Claims Administrator five business days before admission.
- A non-scheduled admission (including Emergency admissions) you must provide notification as soon as is reasonably possible.

In addition, for Out-of-Network Benefits you must obtain prior authorization from the Claims Administrator before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits, with or without medication management. If you fail to obtain prior authorization from or provide notification to the Claims Administrator as required, Benefits will be reduced to 50% of Eligible Expenses. This 50% penalty does not apply toward the Out-of-Pocket Maximum.

For In-Network Benefits it is the participating provider's responsibility to obtain authorization.

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 surgery you must obtain prior authorization five business days before scheduled services are received or for non-scheduled services, within one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses. This 50% penalty does not apply toward the Out-of-Pocket Maximum.

For In-Network Benefits it is the participating provider's responsibility to obtain authorization.

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.

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 the following 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. Services that require prior authorization: dialysis, IV infusion, intensity modulated radiation therapy, and MR-guided focused ultrasound. If you do not obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses. This 50% penalty does not apply toward the Out-of-Pocket Maximum.

For In-Network Benefits it is the participating provider's responsibility to obtain authorization.

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;
- CAR-T cell therapy for malignancies;
- heart;
- heart/lung;
- kidney;
- kidney/pancreas;
- liver;
- liver/kidney;
- liver/intestinal;
- lung/lobar lung;
- multi-visceral;
- pancreas;
- small bowel; and
- small bowel/liver.

Transplantation services including evaluation for transplant, organ procurement and donor searches and transplantation procedures may be received by a Designated Provider, In-Network Provider or Out-of-Network Provider and all are considered at the In-Network Benefit level.

Benefits are also available for cornea transplants. You are not required to obtain prior authorization from the Claims Administrator for a cornea transplant nor is the cornea transplant required to be performed at a Designated Provider.

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.

Prior Authorization Requirement
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). **If you don't obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses. This 50% penalty does not apply toward the Out-of-Pocket Maximum. In addition, for Out-of-Network Benefits you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).**

For In-Network Benefits it is the participating provider's responsibility to obtain authorization.

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.

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 live audio with video technology or audio only. Virtual visits provide communication of medical information in real-time between the patient and a distant Physician or health care specialist, through use of interactive audio with video communications or audio only 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).

Upon completion of Step 1 & 2 of your Wellness Activities under the State of Maryland Wellness Program, you and your spouse will have your copays waived for Virtual Visits.

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 or outpatient facility (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 or outpatient facility every calendar year; and
- vision hardware (frames, lenses, contacts).

Adult Vision

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

Pediatric Vision (Dependent children age 18 and under)

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

Vision hardware (frames, lenses, contacts)

- Frames (one per plan year). 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.

- In-Network -100% of the allowed benefit up to $70; or
- Out-of-Network - 70% of the allowed benefit after the deductible up to $70.

■ Basic Prescription Lenses - Coverage is 100% of the billed charges.

- In-Network -100% of the allowed benefit.
- Out-of-Network - 70% of the allowed benefit after the deductible.

■ Contact lenses (in lieu of frames and lenses). 2 refills per year which is a total of 3 when the first is based on first set at appointment.

- In-Network -100% of the allowed benefit; or
- Out-of-Network - 70% of the allowed benefit after the deductible.

* 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 including necessary hardware after cataract surgery. 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 prolactin.

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 - CLINICAL PROGRAMS AND RESOURCES

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 Management Services.
- Complex Medical Conditions Programs and Services.
- Wellness Programs.
- Women's Health/Reproductive.

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 Plan is a voluntary Wellness Program that is available to all State employees, non-Medicare eligible retirees and enrolled spouses (children are not eligible to participate, regardless of age). If you choose to participate in the Wellness Program the eligible participants will be asked to complete wellness activities throughout the 2021 calendar year. Once these activities are completed, enrollees will enjoy enhanced benefits such as waiving copays for all Primary Care Physician (PCP) visits and/or a $5 reduction on Specialist copays by completing age/gender appropriate preventive screenings.

IMPORTANT
If it is unreasonably difficult due to a medical condition for you or your enrolled Spouse 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.uhcmaryland.com Portal
You are 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.uhcmaryland.com** portal. Simply go to **www.uhcmaryland.com** and follow the directions on the website to register.

If you would like additional information regarding the program, please visit **www.uhcmaryland.com** or call the toll-free number on your ID card.

See Section 3, *How The Plan Works* for complete details on the State of Maryland Wellness Program.

Wellness Program Routine Screenings 2021				
Screening	**18-29 Years**	**30-39 Years**	**40-49 Years**	**50-64 Years**
Routine Checkup	Annually	Every 1-3 Years, depending on risk factors	Every 1-3 Years, depending on risk factors	Annually
Breast Cancer (Women)	Annual Clinical Breast Exam	Annual Clinical Breast Exam	Annual Clinical Breast Exam **And** Annual Mammography	Annual Clinical Breast Exam **And** Annual Mammography
Cervical Cancer	Initial Pap Test at 3 years after first sexual intercourse or by age 21. Then, every 1-3 years per clinician	Every 1-3 years per clinician (Pap test may be performed at 3 year intervals only after 3 consecutive negative results)	Every 1-3 years per clinician (Pap test may be performed at 3 year intervals only after 3 consecutive negative results)	Every 1-3 years per clinician (Pap test may be performed at 3 year intervals only after 3 consecutive negative results)
Colorectal Cancer				Colonoscopy at age 50, then once every 10 years **Or** As recommended by your physician

Diabetes – Type 2			Beginning at age 45: Every 3 years or more often at discretion of physician	Beginning at age 45: Every 3 years or more often at discretion of physician
Tetanus Diphtheria Immunization	3 doses if not previously immunized. Booster every 10 years (one booster should be with Adult dTap vaccine)	3 doses if not previously immunized. Booster every 10 years (one booster should be with Adult dTap vaccine)	3 doses if not previously immunized. Booster every 10 years (one booster should be with Adult dTap vaccine)	3 doses if not previously immunized. Booster every 10 years (one booster should be with Adult dTap vaccine)

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. <u>Excludes</u>: - 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 assessment. 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.

If you need any assistance with the online assessment, please call the number on your ID card.

Reminder Programs

To help you stay healthy, UnitedHealthcare may send you and your covered Dependents reminders to schedule recommended screening exams. Examples of reminders include:

- Mammograms for women.
- Pediatric and adolescent immunizations.
- Cervical cancer screenings for women.
- Comprehensive screenings for individuals with diabetes.
- Influenza/pneumonia immunizations for enrollees.

There is no need to enroll in this program. You will receive a reminder automatically if you have not had a recommended screening exam.

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 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**.

Decision Support

In order to help you make informed decisions about your health care, UnitedHealthcare has a program called 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 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[SM] 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 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, 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 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 your ID card.

HealtheNotes℠

UnitedHealthcare provides a service called HealtheNotes to help educate members and make information regarding your medical care. HealtheNotes provides you and your Physician with information 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 provides this information through a software program that provides retrospective, claims-based identification of medical care. Through this process patients are identified whose care may benefit from this information 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 information. 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 your ID card.

Complex Medical Conditions Programs and Services

Bariatric Resource Services (BRS)

Your Plan offers Bariatric Resource Services (BRS) program. The BRS program provides you with:

- Specialized clinical consulting services to Participants and Enrolled Dependents to educate on obesity treatment options.
- Access to specialized In-Network facilities and Physicians for obesity surgery services.

Cancer Resource Services (CRS) Program

Your Plan offers Cancer Resource Services (CRS) program to provide you with access to information and member assistance through a team of specialized cancer nurse consultants and access to one of the nation's leading cancer programs.

To learn more about *CRS*, visit www.myoptumhealthcomplexmedical.com or call the number on your ID card or call the program directly at 1-866-936-6002.

Coverage for oncology services and oncology-related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary.

Kidney Resource Services (KRS) program
End-Stage Renal Disease (ESRD)

The Kidney Resource Services program provides Covered Persons with access to a registered nurse advocate who specializes in helping individuals live with kidney disease. As a participant in the KRS program, you'll work with a nurse who will provide you with support and information. The nurse can help you manage other conditions, such as diabetes and high blood pressure. He or she can also help you find doctors, specialists and dialysis centers. This program is available at no extra cost to you.

With KRS, you have access to a registered nurse who specializes in kidney health. This program is designed to help you be your own best advocate for your health. You may have been referred to the KRS program by your medical provider or from past claim information. As part of your health insurance benefits, it's available at no extra cost to you.

KRS nurse advocates are available, Monday through Friday toll-free at 1-866-561-7518 (TTY: 711).

Coverage for dialysis and kidney-related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary.

Congenital Heart Disease (CHD) Resource Services

UnitedHealthcare provides a program that identifies and supports a Covered Person who has Congenital Heart Disease (CHD) through all stages of treatment and recovery. This program will work with you and your Physicians, as appropriate, to offer support and education on CHD. Program features include clinical management by specialized CHD Nurses, support from specialized Social Workers, assistance with choosing Physicians and Facilities, and access to Designated Providers.

To learn more about CHD Resource Services program, visit **www.myoptumhealthcomplexmedical.com** or call UnitedHealthcare at the number on your ID card or you can call the CHD Resource Services Nurse Team at 888-936-7246.

Coverage for CHD surgeries and related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary. If you are considering any CHD surgeries you must contact CHD Resource Services prior to surgery to enroll in the program in order for the surgery to be a considered a Covered Health Service under the Plan.

Transplant Resource Services (TRS) Program

Your Plan offers Transplant Resource Services (TRS) program to provide you with access to one of the nation's leading transplant programs. Receiving transplant services through this program means your transplant treatment is based on a "best practices" approach from health care professionals with extensive expertise in transplantation.

To learn more about Transplant Resource Services, visit **www.myoptumhealthcomplexmedical.com** or call the number on your ID card.

Coverage for transplant and transplant-related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary.

Your Plan Sponsor is providing you with Travel and Lodging assistance. For more information on the *Travel and Lodging Assistance Program*, refer to the provision below.

Travel and Lodging Assistance Program

Your Plan Sponsor may provide you with Travel and Lodging assistance. Travel and Lodging assistance is only available for you or your eligible family member if you meet the qualifications for the benefit, including receiving care at a Designated Provider and the distance from your home address to the facility. Eligible Expenses are reimbursed after the expense forms have been completed and submitted with the appropriate receipts.

If you have specific questions regarding the Travel and Lodging Assistance Program, please call the Travel and Lodging office at 1-800-842-0843.

Travel and Lodging Expenses

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 qualified procedure provided by a Designated Provider for the purposes of an evaluation, the procedure or necessary post-discharge follow-up.
- The Eligible Expenses for lodging for the patient (while not a Hospital inpatient) and one companion.
- 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 patient resides more than 50 miles from the Designated Provider.
- Reimbursement for certain lodging expenses for the patient and his/her companion(s) may be included in the taxable income of the Plan participant if the reimbursement exceeds the per diem rate.
- The transplant program offers a lifetime maximum of $10,000 per Covered Person for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures.

The Claims Administrator must receive valid receipts for such charges before you will be reimbursed. Reimbursement is as follows:

Lodging

- A per diem rate, up to $50.00 per day, for the patient or the caregiver if the patient is in the Hospital.
- A per diem, up to $100.00 per day, for the patient and one caregiver. When a child is the patient, two persons may accompany the child.

  Examples of items that are not covered:

  - Groceries.
  - Alcoholic beverages.
  - Personal or cleaning supplies.
  - Meals.
  - Over-the-counter dressings or medical supplies.
  - Deposits.
  - Utilities and furniture rental, when billed separate from the rent payment.
  - Phone calls, newspapers, or movie rentals.

Transportation

- Automobile mileage (reimbursed at the IRS medical rate) for the most direct route between the patient's home and the Designated Provider.
- Taxi fares (not including limos or car services).

- Economy or coach airfare.
- Parking.
- Trains.
- Boat.
- Bus.
- Tolls.

Wellness Programs

Tobacco Cessation Program

UnitedHealthcare provides a tobacco cessation program to help tobacco users withdraw from nicotine dependence. The Quit For Life® program employs an evidence-based combination of physical, psychological and behavioral strategies to help enable you to take responsibility for and overcome your addiction to tobacco use.

If you are a tobacco user, the Quit For Life® program tailors a quitting plan for you and incorporates the following components:

- Multiple planned phone-based coaching sessions.
- Unlimited access to Quit Coach® staff for ongoing support for the duration of your program via toll-free phone and live chat.
- Nicotine replacement therapy (patch or gum) sent to you in conjunction with your quit date.
- Unlimited access to a mobile-friendly online web portal, including support tools that complement your phone-based coaching.
- An online Quit Guide designed to complement your phone-based coaching sessions and web activity.
- Tailored motivational emails sent throughout your quitting process.
- Personalized, interactive text messages.

If you would like to enroll in Quit For Life®, or if you would like additional information regarding the program and also how to access the program online, please call the number on your ID card.

Women's Health/Reproductive

Maternity Support Program

If you are pregnant or thinking about becoming pregnant, and you are enrolled in the medical Plan, you can get valuable educational information, advice and comprehensive case management by calling the number on your ID card. Your enrollment in the program will be handled by an OB nurse who is assigned to you.

This program offers:

- Enrollment by an OB nurse.
- Pre-conception health coaching.
- Written and online educational resources covering a wide range of topics.
- First and second trimester risk screenings.
- Identification and management of at- or high-risk conditions that may impact pregnancy.
- Pre-delivery consultation.
- Coordination with and referrals to other benefits and programs available under the medical plan.
- A phone call from a nurse approximately two weeks postpartum to provide information on postpartum and newborn care, feeding, nutrition, immunizations and more.
- Post-partum depression screening.

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

As a program participant, you can always call your nurse with any questions or concerns you might have.

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;

. aromatherapy;

. hypnotism;

. 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 preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement or the *Health Resources and Services Administration (HRSA)* requirement. This exclusion also does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in Section 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, some type of braces, including orthotic braces available over-the-counter.

3. cranial molding helmets and cranial banding except when used to avoid the need for surgery, and/or to facilitate a successful surgical outcome;

4. powered and non-powered exoskeleton devices;

5. 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;

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

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

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

9. oral appliances for snoring.

Drugs

1. prescription drugs for outpatient use that are filled by a prescription order or refill;

2. self-administered or self-infused 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. This exclusion does not apply to hemophilia treatment centers contracted to dispense hemophilia factor medications directly to Covered Persons for self-infusion;

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;

5. over the counter drugs and treatments;

6. Certain New Pharmaceutical Products and/or new dosage forms until the date as determined by the Claims Administrator or the Claims Administrator's designee, but no later than December 31st of the following calendar year.

   This exclusion does not apply if you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment). If you have a life-threatening Sickness or condition, under such circumstances, Benefits may be available for the New Pharmaceutical Product to the extent provided for in Section 6, Additional Coverage Details;

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;

10. a Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year;

11. certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year; and

12. compounded drugs that contain certain bulk chemicals. Compounded drugs that are available as a similar commercially available Pharmaceutical Product.

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*.

Gender Dysphoria

Cosmetic Procedures, including the following:

1. abdominoplasty;
2. blepharoplasty;
3. breast enlargement, including augmentation mammoplasty and breast implants;
4. body contouring, such as lipoplasty;
5. brow lift;
6. calf implants;
7. cheek, chin, and nose implants;
8. injection of fillers or neurotoxins;

9. face lift, forehead lift, or neck tightening;
10. facial bone remodeling for facial feminizations;
11. hair removal;
12. hair transplantation;
13. lip augmentation;
14. lip reduction;
15. liposuction;
16. mastopexy;
17. pectoral implants for chest masculinization;
18. rhinoplasty;
19. skin resurfacing;
20. thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's Apple) ;
21. voice modification surgery; and
22. voice lessons and voice therapy.

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;
   - gauze and dressings;
   - miscellaneous supplies; and
   - anything purchased over the counter.

   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, Neurobiological Disorders - Autism Spectrum Disorder and Substance -Related and Addictive Disorders Services

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 - Autism Spectrum Disorder Services* and/or *Substance-Related and Addictive Disorders Services* in Section 6, *Additional Coverage Details*.

1. services performed in connection with conditions not classified in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association;*

2. outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association;*

3. outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and disruptive impulse control and conduct disorders, gambling disorder and paraphilic disorders;

4. services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes;

5. tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act*;

6. outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;

7. transitional Living services;

8. non-Medical 24-Hour Withdrawal Management; and

9. high intensity residential care including American Society of Addiction Medicine (ASAM) criteria for Covered Persons with substance-related and addictive disorders who are unable to participate in their care due to significant cognitive impairment.

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);
   - sclerotherapy treatment of veins;
   - 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; and

3. 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*.

17. habilitative services for maintenance/preventive treatment;

188. intracellular micronutrient testing; and

19. health care services provided in the emergency department of a Hospital or Alternate Facility that are not for an Emergency.

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 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 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);

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

4. health services for transplants involving animal organs.

Travel

1. travel or transportation expenses, even if ordered by a Physician, except as identified under *Travel and Lodging Assistance Program* in Section 7, *Clinical Programs and Resources*. Additional travel expenses related to Covered Health Services received from a Designated Provider 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*.

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 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.

Payment of Benefits

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.

To be recognized as a valid assignment of Benefits under the Plan, the assignment must reflect the Covered Person's agreement that the Out-of-Network provider will be entitled to all the Covered Person's rights under the Plan and applicable state and federal laws, including legally required notices and procedural reviews concerning the Covered Person's Benefits, and that the Covered Person will no longer be entitled to those rights. If an assignment form does not comply with this requirement, but directs that your benefit payment should be made directly to the provider, UnitedHealthcare may in its discretion make payment of the benefits directly to the provider for your convenience, but will treat you, rather than the provider, as the beneficiary of your claim. If Benefits are assigned or payment to an Out-of-Network provider is made, State of Maryland reserves the right to offset Benefits to be paid to the provider by any amounts that the provider owes State of Maryland (including amounts owed as a result of the assignment of other plans' overpayment recovery rights to the Plan) pursuant to *Refund of Overpayments* in Section 10, *Coordination of Benefits*.

UnitedHealthcare will pay Benefits to you unless:

- The provider submits a claim form to UnitedHealthcare that you have provided signed authorization to assign Benefits directly to that provider.
- You make a written request for the Out-of-Network provider to be paid directly at the time you submit your claim.

UnitedHealthcare will only pay Benefits to you or, with written authorization by you, your Provider, and not to a third party, even if your provider purports to have assigned Benefits to that third party.

Form of Payment of Benefits

Payment of Benefits under the Plan shall be in cash or cash equivalents, or in the form of other consideration that UnitedHealthcare in its discretion determines to be adequate. Where Benefits are payable directly to a provider, such adequate consideration includes the forgiveness in whole or in part of amounts the provider owes to other plans for which

UnitedHealthcare makes payments, where the Plan has taken an assignment of the other plans' recovery rights for value.

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)

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Plan Sponsor's Self-Funded group medical benefit plan will be coordinated with those of any other plan that provides benefits to you.

When Does Coordination of Benefits Apply?

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

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

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

Definitions

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

A. **Plan**. A Plan is any of the following that provides benefits or services for medical, pharmacy or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

1. Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

2. Plan does not include: hospital indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

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

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

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

D. **Allowable Expense**. For the purposes of COB, an Allowable Expense is a health care expense, including deductibles, coinsurance and copayments, that meets the definition of a Covered Health Service under This Plan. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or according to contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense.

When the provider is an In-Network provider for both the primary plan and this Plan, the allowable expense 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 allowable expense 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 allowable expense 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 allowable expense is the greater of the two Plans' reasonable and customary charges. If this plan is secondary to Medicare, please also refer to the discussion in the section below, titled "Determining the Allowable Expense When this Plan is Secondary to Medicare".

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. **Dependent Child Covered Under More Than One Coverage Plan**. Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

   a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

      (1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or

      (2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.

   b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

      (1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary Plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

      (2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.

(3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.
(4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

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

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

d) (i) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in paragraph (5) applies.
(ii) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in subparagraph (a) to the dependent child's parent(s) and the dependent's spouse.

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

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

5. **Longer or Shorter Length of Coverage**. The Plan that covered the person the longer period of time is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

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

Effect on the Benefits of This Plan

A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, if the Secondary Plan would have paid the same amount or less than the Primary Plan paid, This Plan pays no Benefits; If the Secondary Plan would have paid more than the Primary Plan paid, This Plan will pay the difference; and apply that amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim may be less than the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

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

C. This Coverage Plan reduces its benefits as described below for Covered Persons who are eligible for Medicare when Medicare would be the Primary Plan.
Medicare benefits are determined as if the full amount that would have been payable under Medicare was actually paid under Medicare, even if:

- The person is entitled but not enrolled in Medicare. Medicare benefits are determined as if the person were covered under Medicare.
- The person is enrolled in a Medicare Advantage (Medicare Part C) plan and receives non-covered services because the person did not follow all rules of that plan. Medicare benefits are determined as if the services were covered under Medicare.
- The person receives services from a provider who has elected to opt-out of Medicare. Medicare benefits are determined as if the services were covered under Medicare and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.
- The services are provided in any facility that is not eligible for Medicare reimbursements, including a Veterans Administration facility, facility of the Uniformed Services, or other facility of the federal government. Medicare benefits are determined as if the services were provided by a facility that is eligible for reimbursement under Medicare.
- The person is enrolled under a plan with a Medicare Medical Savings Account. Medicare benefits are determined as if the person were covered under Medicare.

Important: If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under this Coverage Plan), you should enroll for and maintain coverage under both Medicare Part A and Part B. If you don't enroll and maintain that coverage, and if This Plan is secondary to Medicare, This Plan will pay Benefits under this Coverage Plan as if you were covered under both Medicare Part A and Part B. As a result, your out-of-pocket costs will be higher.

If you have not enrolled in Medicare, Benefits will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider if either of the following applies:

- You are eligible for, but not enrolled in, Medicare and this Coverage Plan is secondary to Medicare.
- You have enrolled in Medicare but choose to obtain services from a doctor that opts-out of the Medicare program.

When calculating this Coverage Plan's Benefits in these situations for administrative convenience, the Claims Administrator may, as the Claims Administrator determines, treat the provider's billed charges, rather than the Medicare approved amount or Medicare limiting charge, as the Allowable Expense for both this Coverage Plan and Medicare.

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 Claims Administrator may get the facts the Claims Administrator needs 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.

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

Payments Made

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

Does This Plan Have the Right of Recovery?

If the amount of the payments This Plan made is more than This Plan should have paid under this COB provision, This Plan may recover the excess from one or more of the persons This Plan have paid or for whom This Plan have paid; or any other person or

organization that may be responsible for the benefits or services provided for you. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

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 the Plan 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 Plan Sponsor may recover the amount in the form of salary, wages, or benefits payable under any Plan Sponsor-funded benefit plans, including this Plan. The Plan Sponsor also reserves the right to recover any overpayment by legal action or offset payments on future allowable expenses.

If the Plan overpays a health care provider, the Plan 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 you, you, 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 you, but all or some of the expenses were not paid by you or did not legally have to be paid by you.
- All or some of the payment the Plan made exceeded the Benefits under the Plan.
- 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 been paid under the Plan. If the refund is due from another person or organization, you agree to help the Plan get the refund when requested.

If the refund is due from you and you do 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, future Benefits for you that are payable under the Plan. If the refund is due from a person or organization other than you, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Plan; or (ii) future Benefits that are payment in connection with services provided to persons under other plans for which the Claims Administrator processes payments, pursuant to a transaction in which the Plan's overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment. The reallocated payment amount will either:

- 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.

How Are Benefits Paid When This Plan is Secondary to Medicare?

If This Plan is secondary to Medicare, then Benefits payable under This Plan will be based on Medicare's reduced benefits.

What is Different When You Qualify for Medicare?

Determining Which Plan is Primary When You Qualify for Medicare

As 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 (however, domestic partners are excluded as provided by Medicare).
- Individuals with end-stage renal disease, for a limited period of time.
- Disabled individuals under age 65 with current employment status and their Dependents under age 65.

Determining the Allowable Expense When this Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts reimbursement directly from Medicare. If the provider accepts reimbursement directly from Medicare, the Medicare approved amount is the charge that Medicare has determined that it will recognize and which it reports on an "explanation of Medicare benefits" issued by Medicare (the "EOMB") for a given service. Medicare typically reimburses such providers a percentage of its approved charge – often 80%.

If the provider does not accept assignment of your Medicare benefits, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare – typically 115% of the Medicare approved amount) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the allowable expense.

If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, or if you have enrolled in Medicare but choose to obtain services from a provider that does not participate in the Medicare program (as opposed to a provider who does not accept assignment of Medicare benefits), Benefits will be paid on a secondary basis under this Plan and will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider.

When calculating the Plan's Benefits in these situations, and when Medicare does not issue an EOMB, for administrative convenience the Claims Administrator will treat the provider's billed charges for covered services as the allowable expense for both the Plan and Medicare, rather than the Medicare approved amount or Medicare limiting charge.

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

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

Medicare Crossover Program

The Plan offers a Medicare Crossover program for Medicare Part A and Part B and Durable Medical Equipment (DME) claims. Under this program, you no longer have to file a separate claim with the Plan to receive secondary benefits for these expenses. Your Dependent will also have this automated Crossover, as long as he or she is eligible for Medicare and this Plan is your only secondary medical coverage.

Once the Medicare Part A and 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.

You can verify that the automated crossover took place when your copy of the explanation of Medicare benefits (EOMB) states your claim has been forwarded to your secondary carrier.

This crossover process does not apply to 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 your ID card.

SECTION 11 - SUBROGATION AND REIMBURSEMENT

The Plan has a right to subrogation and reimbursement. References to "you" or "your" in this *Subrogation and Reimbursement* section shall include you, your estate and your heirs and beneficiaries unless otherwise stated.

Subrogation applies when the plan has paid Benefits on your behalf for a Sickness or Injury for which any third party is allegedly 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 any third party is considered 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 it is alleged that any third party caused or is responsible for 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 receive for that Sickness or Injury. The right of reimbursement shall apply to any Benefits received at any time until the rights are extinguished, resolved or waived in writing.

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 in a workers' compensation case or other matter alleging liability.
- 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.

- Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a Sickness or Injury you allege or could have alleged were the responsibility of any third party.
- 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.
  - 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 any 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, your estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium 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 and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
- By participating in and accepting Benefits from the Plan, you agree that (i) any amounts recovered by you from any third party shall constitute Plan assets to the extent of the amount of Plan Benefits provided on behalf of the Covered Person, (ii) you and your representative shall be fiduciaries of the Plan (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the Plan to enforce its reimbursement rights.
- The Plan's rights to recovery will not be reduced due to your own negligence.
- By participating in and accepting Benefits from the Plan, you agree to assign to the Plan any Benefits, claims or rights of recovery you have under any automobile policy - including no-fault Benefits, PIP Benefits and/or medical payment Benefits - other coverage or against any third party, to the full extent of the Benefits the Plan has paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting Benefits, you acknowledge and recognize the Plan's right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.
- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical Benefits you receive for the Sickness or Injury out of any settlement, judgment or other recovery from any third party considered responsible and filing suit in your name or your estate's name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund Benefits as required under the terms of the Plan is governed by a six-year statute of limitations.
- 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 death, giving rise to any 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. In the case of your death the Plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.
- 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 any 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 any 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.
- In the event that you do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate Benefits to you, your dependents or the employee, 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 your failure to abide by the terms of 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 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.
- 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.
- 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.
- 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:

- last day of the month your employment with the Group ends;
- 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 last day of the month based on when your Dependent no longer qualifies as a Dependent under this Plan;
- the end of the month in which your eligible child, stepchild or adopted child turns age 26; or
- the end of the month in which your eligible grandchild, legal ward or other child relative turns age 25.

Other Events Ending Your Coverage

The Plan will provide at least thirty days' 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, knowingly providing incorrect information relating to another person's eligibility or status as a Dependent. You may appeal this decision during the 30-day notice period. The notice will contain information on how to pursue your appeal.

Note: If UnitedHealthcare and State of Maryland find that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact State of Maryland has the right to demand that you pay back all 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 has a **permanent** disability;
- 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.

You are not required to provide disability certification until a disabled, eligible dependent child reaches age 26. You will then be required to provide certification of his/her permanent disability status to keep him/her on your coverage. Note: The onset of disability must have occurred before the child reached age 26.

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 the service fee to UnitedHealthcare;
- the funding of Benefits on a timely basis; 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. 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 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.

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

The relationship between you and State of Maryland is that of employer and employee, Dependent or other classification as defined in this EOC.

Interpretation of Benefits

State of Maryland and UnitedHealthcare have the sole and exclusive discretion to do all of the following:

- Interpret Benefits under the Plan.
- Interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD the Schedule of Benefits and any Addendums, SMMs and/or Amendments.
- 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 including Claims Administrator's affiliates that may provide services in regard to the administration of the Plan. The identity of the service providers and the nature of their services may be changed from time to time in Plan Sponsor's and the Claims Administrator's discretion. In order to receive Benefits, you must cooperate with those service providers.

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;
- 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; or
- bundled payments - certain In-Network providers receive a bundled payment for a group of Covered Health Services for a particular procedure or medical condition. Your Copayment and/or Coinsurance will be calculated based on the provider type that received the bundled payment. The In-Network providers receive these bundled

payments regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment. If you receive follow-up services related to a procedure where a bundled payment is made, an additional Copayment and/or Coinsurance may not be required if such follow-up services are included in the bundled payment. You may receive some Covered Health Services that are not considered part of the inclusive bundled payment and those Covered Health Services would be subject to the applicable Copayment and/or Coinsurance as described in your *Schedule of Benefits*.

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, surveys, discount programs and/or programs to seek care in a more cost effective setting and/or from Designated Providers. In some instances, these programs may be offered in combination with a non-UnitedHealthcare entity. 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 your ID card if you have any questions. Additional information may be found in Section 7, *Clinical Programs and Resources*.

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 may pass a portion of these rebates on to you. When rebates are passed on to you, they may be 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.

Review and Determine Benefits in Accordance with UnitedHealthcare Reimbursement Policies

UnitedHealthcare develops its reimbursement policy guidelines, in its sole discretion, in accordance with one or more of the following methodologies:

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

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), UnitedHealthcare's reimbursement policies are applied to provider billings. UnitedHealthcare shares its reimbursement policies with Physicians and other providers in UnitedHealthcare's Network through UnitedHealthcare's provider website. In-Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by UnitedHealthcare's reimbursement policies) and the billed charge. However, Out-of-Network providers are not subject to this prohibition, and may bill you for any amounts the Plan does not pay, including amounts that are denied because one of UnitedHealthcare's reimbursement policies does not reimburse (in whole or in part) for the service billed. You may obtain copies of UnitedHealthcare's reimbursement policies for yourself or to share with your Out-of-Network Physician or provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.

UnitedHealthcare may apply a reimbursement methodology established by *OptumInsight* and/or a third party vendor, which is based on *CMS* coding principles, to determine appropriate reimbursement levels for Emergency Health Care Services. The methodology is usually based on elements reflecting the patient complexity, direct costs, and indirect costs of an Emergency Health Care Service. If the methodology(ies) currently in use become no longer available, UnitedHealthcare will use a comparable methodology(ies). 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 methodology.

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-Related and Addictive Disorders 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.

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

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:

- provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms;
- Medically Necessary;
- 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 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.

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

Dependent - 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 Provider - a provider and/or facility that:

- Has entered into an agreement with UnitedHealthcare, or with an organization contracting on UnitedHealthcare's behalf, to provide Covered Health Services for the treatment of specific diseases or conditions; or
- UnitedHealthcare has identified through UnitedHealthcare's designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures.

A Designated Provider may or may not be located within your geographic area. Not all In-Network Hospitals or In-Network Physicians are Designated Providers.

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

Designated Virtual Network Provider - a provider or facility that has entered into an agreement with 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.

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

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

Emergency Health Services – with respect to an Emergency, both of the following:

- A medical screening examination (as required under section *1867 of the Social Security Act, 42 U.S.C. 1395dd)* that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency.

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

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 - A disorder characterized by the following diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*:

- Diagnostic criteria for adults and adolescents:
  - A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least two of the following:
    - ♦ A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
    - ♦ A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
    - ♦ A strong desire for the primary and/or secondary sex characteristics of the other gender.
    - ♦ A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
    - ♦ A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
    - ♦ A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).
  - The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning.
- Diagnostic criteria for children:
  - A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least six of the following (one of which must be criterion as shown in the first bullet below):
    - ♦ A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
    - ♦ In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
    - ♦ A strong preference for cross-gender roles in make-believe play or fantasy play.

- ♦ A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender.
- ♦ A strong preference for playmates of the other gender.
- ♦ In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games and activities.
- ♦ A strong dislike of ones' sexual anatomy.
- ♦ A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.

- The condition is associated with clinically significant distress or impairment in social, school or other important areas of functioning.

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

Genetic Counseling - counseling by a qualified clinician that includes:

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

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

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

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

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-related and addictive 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.

Infertility - A disease (an interruption, cessation, or disorder of body functions, systems, or organs) of the reproductive tract which prevents the conception of a child or the ability to carry a pregnancy to delivery. It is defined by the failure to achieve a successful pregnancy after 12 months or more of appropriate, timed unprotected intercourse or Therapeutic Donor Insemination. Earlier evaluation and treatment may be justified based on medical history and physical findings and is warranted after 6 months for women age 35 years or older.

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 Behavioral Therapy (IBT) - outpatient behavioral/educational services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders. Examples

include *Applied Behavior Analysis (ABA)*, *The Denver Model*, and *Relationship Development Intervention (RDI)*.

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 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, service site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders disease or its symptoms.

- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s) , service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

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

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. 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.UHCprovider.com.**

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

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

Mental Health/Substance-Related and Addictive Disorders Services Administrator - the organization or individual designated by State of Maryland who provides or arranges Mental Health and Substance-Related and Addictive Disorder Services under the Plan.

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

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

- The date it is reviewed.
- December 31st of the following calendar year.

Non-Medical 24-Hour Withdrawal Management - An organized residential service, including those defined in *American Society of Addiction Medicine (ASAM)*, providing 24-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care.

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

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

Please note: Any podiatrist, dentist, psychologist, chiropractor, optometrist or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that 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.

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

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

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.

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:

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

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 - treatment in a facility which provides Mental Health Services or Substance-Related and Addictive Disorders Services treatment. The facility 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-Related and Addictive Disorders 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 the wellness activities in the current calendar year and a $5 reduction on Specialist copays by completing age/gender appropriate preventive screenings.

Substance-Related and Addictive Disorders Services – services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Surrogate - a female who becomes pregnant usually by artificial insemination or transfer of a fertilized egg (embryo) for the purpose of carrying the fetus for another person. When the surrogate provides the egg the surrogate is biologically (genetically) related to the child.

Therapeutic Donor Insemination (TDI) - Insemination with a donor sperm sample for the purpose of conceiving a child.

Transitional Living - Mental Health Services and Substance-Related and Addictive Disorders Services that are provided through facilities, group homes and supervised apartments that provide 24-hour supervision, including those defined in *American Society of Addiction Medicine (ASAM)* criteria, that are either:

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

- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments that provide stable and safe housing and the opportunity to learn how to manage 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 - care that requires prompt attention to avoid adverse consequences, but does not pose an immediate threat to a person's life. Urgent care is usually delivered in a walk-in setting and without an appointment. Urgent care facilities are a location, distinct from a hospital emergency department, an office or a clinic. The purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

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

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 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 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.

ATTACHMENT III – NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS

When the Plan uses the words "Claims Administrator" in this Attachment, it is a reference to United HealthCare Services, Inc., on behalf of itself and its affiliated companies.

The Claims Administrator on behalf of itself and its affiliated companies complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. UnitedHealthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Claims Administrator provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as: Qualified interpreters
- Information written in other languages

If you need these services, please call the toll-free member number on your health plan ID card, TTY 711 or the Plan Sponsor.

If you believe that the Claims Administrator has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in writing by mail or email with the Civil Rights Coordinator identified below. A grievance must be sent within 60 calendar days of the date that you become aware of the discriminatory action and contain the name and address of the person filing it along with the problem and the requested remedy.

A written decision will be sent to you within 30 calendar days. If you disagree with the decision, you may file an appeal within 15 calendar days of receiving the decision.

Claims Administrator Civil Rights Coordinator
United HealthCare Services, Inc. Civil Rights Coordinator UnitedHealth**c**are Civil Rights Grievance P.O. Box 30608 Salt Lake City, UT 84130 The toll-free member phone number listed on your health plan ID card, TTY 711 UHC_Civil_Rights@UHC.com

If you need help filing a grievance, the Civil Rights Coordinator identified above is available to help you.

You can also file a complaint directly with the U.S. Dept. of Health and Human services online, by phone or mail:

Online https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201

ATTACHMENT IV – GETTING HELP IN OTHER LANGUAGES OR FORMATS

You have the right to get help and information in your language at no cost. To request an interpreter, call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711.

This letter is also available in other formats like large print. To request the document in another format, please call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

Language	Translated Taglines
1. Albanian	Ju keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të kërkuar një përkthyes, telefononi në numrin që gjendet në kartën e planit tuaj shëndetësor, shtypni 0. TTY 711.
2. Amharic	ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። አስተርጓሚ እንዲቀርብልዎ ከፈለጉ በጤና ፕላን መታወቂያዎት ላይ ባለው በተጻ መስመር ስልክ ቁጥር ይደውሉና 0ን ይጫኑ። TTY 711
3. Arabic	لك الحق في الحصول على المساعدة والمعلومات بلغتك دون تحمل أي تكلفة. لطلب مترجم فوري، اتصل برقم الهاتف المجاني الخاص بالأعضاء المدرج ببطاقة مُعرّف العضوية الخاصة بخطتك الصحية، واضغط على 0. الهاتف النصي (TTY) 711
4. Armenian	Թարգմանիչ պահանջելու համար, զանգահարե՛ք Ձեր առողջապահական ծրագրի ինքնության (ID) տոմսի վրա նշված անվճար Անդամների հեռախոսահամարով, սեղմե՛ք 0: TTY 711
5. Bantu-Kirundi	Urafise uburenganzira bwo kuronka ubufasha n'amakuru mu rurimi rwawe ku buntu. Kugira usabe umusemuzi, hamagara inomero ya telephone y'ubuntu yagenewe abanywanyi iri ku rutonde ku karangamuntu k'umugambi wawe w'ubuzima, fyonda 0. TTY 711
6. Bisayan-Visayan (Cebuano)	Aduna kay katungod nga mangayo og tabang ug impormasyon sa imong lengguwahe nga walay bayad. Aron mohangyo og tighubad, tawag sa toll-free nga numero sa telepono sa miyembro nga nakalista sa imong ID kard sa plano sa panglawas, pindota ang 0. TTY 711
7. Bengali-Bangala	অনুবাদকের অনুরোধ থাকলে, আপনার স্বাস্থ্য পরিকল্পনার আই ডি কার্ড এ তালিকাভূক্ত ও কর দিতে হবে না এমন টেলিফোন নম্বরে ফোন করুন। (০) শূণ্য চাপুন। TTY 711
8. Burmese	ကုန်ကျစရိတ်ပေးရန်မလိုဘဲ မိမိဘာသာစကားဖြင့် အကူအညီနှင့် သတင်းအချက်အလက်များ ကိုရယူနိုင်ခြင်း သည်သင်၏အခွင့်အရေးဖြစ်သည်။ စကားပြန်တစ်ဦးတောင်းဆိုရန်သင်၏ကျန်းမာရေးအစီအစဉ် လက်မှတ်ပေါ်ရှိအသင်းဝင်များအတွက်အခမဲ့ဖုန်းလိုင်းသို့ခေါ်ဆိုပြီး 0 ကိုနှိပ်ပါ။ TTY 711
9. Cambodian-Mon-Khmer	អ្នកមានសិទ្ធិទទួលជំនួយ និងព័ត៌មាន ជាភាសារបស់អ្នក ដោយមិនអស់ថ្លៃ។ ដើម្បីស្នើសុំអ្នកបកប្រែ សូមទូរស័ព្ទទៅលេខឥតចេញថ្លៃ សំរាប់សមាជិក ដែលមានកត់នៅក្នុងប័ណ្ណ ID គំរោងសុខភាពរបស់អ្នក រួចហើយចុច 0។ TTY 711
10. Cherokee	Ꮎ ᎠᏎᏪ ᏥᎵ ᏗᏟᏃᏢᏗ ᏗᏎᏍᏗ ᏥᎪᏜᎳ ᎢᏓ ᏣᏤᎵ ᏙᎯ ᏥᏒ ᏗᎫᎪᏙᏗ ᎠᏟᏍᏙᏗ ᏆᎾᏲᏍᏗᎢ, ᏧᏐᏫᏍᏓ 0. TTY 711

Language	Translated Taglines
11. Chinese	您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥打您健保計劃會員卡上的免付費會員電話號碼，再按 0。聽力語言殘障服務專線 711
12. Choctaw	Chim anumpa ya, apela micha nana aiimma yvt nan aivlli keyu ho ish isha hinla kvt chim aiivlhpesa. Tosholi ya asilhha chi hokmvt chi achukmaka holisso kallo iskitini ya tvli aianumpuli holhtena ya ibai achvffa yvt peh pila ho ish i paya cha 0 ombetipa. TTY 711
13. Cushite-Oromo	Kaffaltii male afaan keessaniin odeeffannoofi deeggarsa argachuuf mirga ni qabdu. Turjumaana gaafachuufis sarara bilbilaa kan bilisaa waraqaa eenyummaa karoora fayyaa keerratti tarreefame bilbiluun, 0 tuqi. TTY 711
14. Dutch	U heeft het recht om hulp en informatie in uw taal te krijgen zonder kosten. Om een tolk aan te vragen, bel ons gratis nummer die u op uw ziekteverzekeringskaart treft, druk op 0. TTY 711
15. French	Vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour demander à parler à un interprète, appelez le numéro de téléphone sans frais figurant sur votre carte d'affilié du régime de soins de santé et appuyez sur la touche 0. ATS 711.
16. French Creole-Haitian Creole	Ou gen dwa pou jwenn èd ak enfòmasyon nan lang natifnatal ou gratis. Pou mande yon entèprèt, rele nimewo gratis manm lan ki endike sou kat ID plan sante ou, peze 0. TTY 711
17. German	Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um einen Dolmetscher anzufordern, rufen Sie die gebührenfreie Nummer auf Ihrer Krankenversicherungskarte an und drücken Sie die 0. TTY 711
18. Greek	Έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να ζητήσετε διερμηνέα, καλέστε το δωρεάν αριθμό τηλεφώνου που βρίσκεται στην κάρτα μέλους ασφάλισης, πατήστε 0. TTY 711
19. Gujarati	તમને વિના મૂલ્યે મદદ અને તમારી ભાષામાં માહિતી મેળવવાનો અધિકાર છે. દુભાષિયા માટે વિનંતી કરવા, તમારા હેલ્થ પ્લાન ID કાર્ડ પરની સૂચીમાં આપેલ ટોલ-ફ્રી મેમ્બર ફોન નંબર ઉપર કોલ કરો, 0 દબાવો. TTY 711
20. Hawaiian	He pono ke kōkua ʻana aku iā ʻoe ma ka maopopo ʻana o kēia ʻike ma loko o kāu ʻōlelo ponoʻī me ka uku ʻole ʻana. E kamaʻilio ʻoe me kekahi kanaka unuhi, e kāhea i ka helu kelepona kāki ʻole ma kou kāleka olakino, a e kaomi i ka helu 0. TTY 711.

Language	Translated Taglines
21. Hindi	आप के पास अपनी भाषा में सहायता एवं जानकारी नि:शुल्क प्राप्त करने का अधिकार है। दुभाषिए के लिए अनुरोध करने के लिए, अपने हैल्थ प्लान ID कार्ड पर सूचीबद्ध टोल-फ्री नंबर पर फ़ोन करें, 0 दबाएं। TTY 711
22. Hmong	Koj muaj cai tau kev pab thiab tau cov ntaub ntawv sau ua koj hom lus pub dawb. Yog xav tau ib tug neeg txhais, hu tus xov tooj rau tswv cuab hu dawb uas sau muaj nyob ntawm koj daim yuaj them nqi kho mob, nias 0. TTY 711.
23. Ibo	Inwere ikike inweta enyemaka nakwa ịmụta asụsụ gị n'efu n'akwughị ụgwọ. Maka ịkpọtụrụ onye nsụgharị okwu, kpọọ akara ekwentị nke dị nákwụkwọ njirimara gị nke emere maka ahụike gị, pịa 0. TTY 711.
24. Ilocano	Adda karbengam nga makaala ti tulong ken impormasyon iti pagsasaom nga libre. Tapno agdawat iti maysa nga agipatarus, tumawag iti toll-free nga numero ti telepono nga para kadagiti kameng nga nakalista ayan ti ID card mo para ti plano ti salun-at, ipindut ti 0. TTY 711
25. Indonesian	Anda berhak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa dikenakan biaya. Untuk meminta bantuan penerjemah, hubungi nomor telepon anggota, bebas pulsa, yang tercantum pada kartu ID rencana kesehatan Anda, tekan 0. TTY 711
26. Italian	Hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per richiedere un interprete, chiama il numero telefonico verde indicato sulla tua tessera identificativa del piano sanitario e premi lo 0. Dispositivi per non udenti/TTY: 711
27. Japanese	ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳をご希望の場合は、医療プランのID カードに記載されているメンバー用のフリーダイヤルまでお電話の上、0を押してください。TTY 専用番号は 711です。
28. Karen	နအိဉ်ဒီးတါ်ခွဲးတါ်ယာ်လၢနုကဒီးနဲ့ဘဉ်တါ်မၤစၢၤဒီးတါ်ဂ့ါတါ်ကျိုၤလၢနုကျိုဉ်ဒဉ်နဝဲလၢတဝိဉ်ဟုဉ်အပူၤဘဉ်နှဉ်လီၤ.လၢတါ်ကဃ့နှါပူၤကတိၤကျိုးထံတါ်တက၊အဂီၢ်ကီးဘဉ်လီတဖိအကျိုၤလၢကရၢဖိအတဝိဉ်ဟုဉ်အပူၤလၢအအိဉ်လၢနုတါ်အိဉ်ဆူဉ်အိဉ်ချုအတါ်ရဲဉ်တါ်ကျဲၤအကၢးအလိၤဒီးဆိဉ်လီၤနိုၢ်ဂ်ၢ် 0 တက့ၢ်.TTY 711
29. Korean	귀하는 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 통역사를 요청하기 위해서는 귀하의 플랜 ID카드에 기재된 무료 회원 전화번호로 전화하여 0번을 누르십시오. TTY 711
30. Kru- Bassa	Ni gwe kunde I bat mahola ni mawin u hop nan nipehmes be to dolla. Yu kwel ni Kobol mahop seblana, soho ni sebel numba I ni tehe mu I ticket I docta I nan, bep 0. TTY 711

Language	Translated Taglines
31. Kurdish-Sorani	مافەی ئەوەت هەیە کە بێبەرامبەر، یارمەتی و زانیاری پێویست بە زمانی خۆت وەرگریت. بۆ داواکردنی وەرگێڕێکی زارەکی، پەیوەندی بکە بە ژمارە تەلەفۆنی نووسراو لەناو ئای دی کارتی پیناسەیی پلانی تەندروستی خۆت و پاشان 0 داگرە .TTY 711
32. Laotian	ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຂໍຮ້ອງນາຍພາສາ,ໂທຟຣີຫາຫມາຍເລກໂທລະສັບສໍາລັບສະມາຊິກທີ່ໄດ້ລະບຸໄວ້ໃນບັດສະມາຊິກຂອງທ່ານ,ກົດເລກ 0. TTY 711
33. Marathi	आपल्याला आपल्या भाषेत विनामूल्य मदत आणि माहिती मिळण्याचा अधिकार आहे. दूभाषकास विनंती करण्यासाठी आपल्या आरोग्य योजना ओळखपत्रावरील सूचीबध्द केलेल्या सदस्यास विनामूल्य फोन नंबरवर संपर्क करण्यासाठी दाबा 0. TTY 711
34. Marshallese	Eor aṃ maroñ ñan bok jipañ im meḷeḷe ilo kajin eo aṃ ilo ejjeḷọk wōṇāān. Ñan kajjitōk ñan juon ri-ukok, kūrḷok nōṃba eo eṃōj an jeje ilo kaat in ID in karōk in ājmour eo aṃ, jiped 0. TTY 711
35. Micronesian-Pohnpeian	Komw ahneki manaman unsek komwi en alehdi sawas oh mengihtik ni pein omwi tungoal lokaia ni soh isepe. Pwen peki sawas en soun kawehweh, eker delepwohn nempe ong towehkan me soh isepe me ntingihdi ni pein omwi doaropwe me pid koasoandi en kehl, padik 0. TTY 711.
36. Navajo	T'áá jíík'eh doo bą́ą́h 'alínígóó bee baa hane'ígíí t'áá ni nizaád bee niká'e'eyeego bee ná'ahoot'i'. 'Ata' halne'í ła yíníkeedgo, ninaaltsoos nit ‘iz7 ‘ats’77s bee baa’ahay1 bee n44hozin7g77 bik11’ b44sh bee hane’7 t’11 j77k’eh bee hane’7 bik1’7g77 bich’8’ hodíilnih dóó 0 bił 'adidíílchił. TTY 711
37. Nepali	तपाईंले आफ्नो भाषामा निःशुल्क सहयोग र जानकारी प्राप्त गर्ने अधिकार तपाईसँग छ। अनुवादक प्राप्त गरीपाऊँ भनी अनुरोध गर्न, तपाईंको स्वास्थ्य योजना परिचय कार्डमा सूचीकृत टोल-फ्री सदस्य फोन नम्बरमा सम्पर्क गर्नुहोस्, 0 थिच्नुहोस्। TTY 711
38. Nilotic-Dinka	Yin nɔŋ löŋ bë yi kuɔny në wërëyic de thöŋ du äbac ke cin wëu tääue ke piny. Äcän bä ran yë kɔc ger thok thiëëc, ke yin cɔl nämba yene yup abac de ran töŋ ye kɔc wäär thok tɔ në ID kat duön de pänakim yic, thäny 0 yic. TTY 711.
39. Norwegian	**Du har rett til å få gratis hjelp og informasjon på ditt eget språk. For å be om en tolk, ring gratisnummeret for medlemmer som er oppført på helsekortet ditt og trykk 0. TTY 711**
40. Pennsylvania Dutch	Du hoscht die Recht fer Hilf unn Information in deine Schprooch griege, fer nix. Wann du en Iwwersetzer hawwe willscht, kannscht du die frei Telefon Nummer uff dei Gesundheit Blann ID Kaarde yuuse, dricke 0. **TTY 711**

Language	Translated Taglines
41. Persian-Farsi	شما حق دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. برای درخواست مترجم شفاهی با شماره تلفن رایگان قید شده در کارت شناسایی برنامه بهداشتی خود تماس حاصل نموده و 0 را فشار دهید. TTY 711
42. Punjabi	ਤੁਹਾਡੇ ਕੋਲ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਅਤੇ ਜਾਣਕਾਰੀ ਮੁਫ਼ਤ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ| ਦੁਭਾਸ਼ੀਏ ਲਈ ਤੁਹਾਡੇ ਹੈਲਥ ਪਲਾਨ ਆਈਡੀ ਦਿੱਤੇ ਗਏ ਟਾੱਲ ਫ੍ਰੀ ਮੈਂਬਰ ਫ਼ੋਨ ਨੰਬਰ ਟੀਟੀਵਾਈ 711 ਤੇ ਕਾੱਲ ਕਰੋ, 0 ਦੱਬੋ|
43. Polish	Masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Po usługi tłumacza zadzwoń pod bezpłatny numer umieszczony na karcie identyfikacyjnej planu medycznego i wciśnij 0. TTY 711
44. Portuguese	Você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para solicitar um intérprete, ligue para o número de telefone gratuito que consta no cartão de ID do seu plano de saúde, pressione 0. TTY 711
45. Romanian	Aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a cere un interpret, sunați la numărul de telefon gratuit care se găsește pe cardul dumneavoastră de sănătate, apăsați pe tasta 0. TTY 711
46. Russian	Вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы подать запрос переводчика позвоните по бесплатному номеру телефона, указанному на обратной стороне вашей идентификационной карты и нажмите 0. Линия TTY 711
47. Samoan-Fa'asamoa	E iai lou āiā tatau e maua atu ai se fesoasoani ma fa'amatalaga i lau gagana e aunoa ma se totogi. Ina ia fa'atalosagaina se tagata fa'aliliu, vili i le telefoni mo sui e le totogia o loo lisi atu i lau peleni i lau pepa ID mo le soifua maloloina, oomi le 0. TTY 711.
48. Serbo-Croation	Imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste zatražili prevodioca, nazovite besplatni broj naveden na iskaznici Vašeg zdravstenog osiguranja i pritisnite 0. TTY 711.
49. Spanish	Tiene derecho a recibir ayuda e información en su idioma sin costo. Para solicitar un intérprete, llame al número de teléfono gratuito para miembros que se encuentra en su tarjeta de identificación del plan de salud y presione 0. TTY 711
50. Sudanic-Fulfulde	Ɗum hakke maaɗa mballeɗaa kadin keɓaa habaru nder wolde maaɗa naa maa a yoɓii. To a yiɗi pirtoowo, noddu limngal mo telefol caahu limtaaɗo nder kaatiwol ID maaɗa ngol njamu, nyo"u 0. TTY 711.

Language	Translated Taglines
51. Swahili	Una haki ya kupata msaada na taarifa kwa lugha yako bila gharama. Kuomba mkalimani, piga nambariya wanachama ya bure iliyoorodheshwa kwenye TAM ya kadi yako ya mpango wa afya, bonyeza 0. TTY 711
52. Syriac-Assyrian	ܐܚܬܘܢ ܐܝܬܠܘܟ݂ܘܢ ܙܕܩܘܬܐ ܕܩܒܠܬܘܢ ܗܝܪܬܐ ܘܡܘܕܥܢܘܬܐ ܒܠܫܢܘܟ݂ܘܢ ܡܓܢܐܝܬ ܠܡܫܬܥܝܐ ܥܡ ܚܕ ܡܬܪܓܡܢܐ، ܩܪܘܢ ܥܠ ܡܢܝܢܐ ܡܓܢܝܐ ܕܐܝܠܗ ܥܠ ܒܛܩܐ ܐܝܕܝ ܦܠܢܐ ܕܚܘܠܡܢܐ ܘܕܘܫ 0 .TTY 711
53. Tagalog	May karapatan kang makatanggap ng tulong at impormasyon sa iyong wika nang walang bayad. Upang humiling ng tagasalin, tawagan ang toll-free na numero ng telepono na nakalagay sa iyong ID card ng planong pangkalusugan, pindutin ang 0. TTY 711
54. Telugu	ఎలాంటి ఖర్చు లేకుండా మీ భాషలో సాయంబు మరియు సమాచార పొంద డానికి మీకు హక్కు ఉంది. ఒకవేళ దుబాషి కావాలంటే, మీ హెల్త్ ప్లాన్ ఐడి కార్డు మీద జాబితా చేయబడ్డ టోల్ ఫ్రీ నెంబరుకు ఫోన్ చేసి, 0 ప్రెస్ చేస్కో. TTY 711
55. Thai	คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย หากต้องการขอล่ามแปลภาษา โปรดโทรศัพท์ถึงหมายเลขโทรฟรีที่อยู่บนบัตรประจำตัวสำหรับแผนสุขภาพของคุณ แล้วกด 0 สำหรับผู้ที่มีความบกพร่องทางการได้ยินหรือการพูด โปรดโทรฯถึงหมายเลข 711
56. Tongan-Fakatonga	‘Oku ke ma’u ‘a e totonu ke ma’u ’a e tokoni mo e ‘u fakamatala ‘i ho’o lea fakafonua ta’etotongi. Ke kole ha tokotaha fakatonulea, ta ki he fika telefoni ta’etotongi ma’ae kau memipa ‘a ee ‘oku lisi ‘I ho’o kaati ID ki ho’o palani ki he mo’uilelei, Lomi’I ‘a e 0. TTY 711
57. Trukese (Chuukese)	Mi wor omw pwung om kopwe nounou ika amasou noum ekkewe aninis ika toropwen aninis nge epwe awewetiw non kapasen fonuom, ese kamo. Ika ka mwochen tungoren aninisin chiakku, kori ewe member nampa, ese pwan kamo, mi pachanong won an noum health plan katen ID, iwe tiki "0". Ren TTY, kori 711.
58. Turkish	Kendi dilinizde ücretsiz olarak yardım ve bilgi alma hakkınız bulunmaktadır. Bir tercüman istemek için sağlık planı kimlik kartınızın üzerinde yer alan ücretsiz telefon numarasını arayınız, sonra 0’a basınız. TTY (yazılı iletişim) için 711
59. Ukrainian	У Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб подати запит про надання послуг перекладача, зателефонуйте на безкоштовний номер телефону учасника, вказаний на вашій ідентифікаційній карті плану медичного страхування, натисніть 0. TTY 711
60. Urdu	آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ کسی ترجمان سے بات کرنے کے لئے، ٹول فری ممبر فون نمبر پر کال کریں جو آپ کے ہیلتھ پلان آئی ڈی کارڈ پر درج ہے، 0 دبائیں۔ TTY 711

Language	Translated Taglines
61. Vietnamese	Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu được thông dịch viên giúp đỡ, vui lòng gọi số điện thoại miễn phí dành cho hội viên được nêu trên thẻ ID chương trình bảo hiểm y tế của quý vị, bấm số 0. TTY 711
62. Yiddish	איר האט די רעכט צו באקומען הילף און אינפארמאציע אין אייער שפראך פריי פון אפצאל. צו פארלאנגען א דאלמעטשער, רופט דעם טאל פרייע מעמבער טעלעפאן נומער וואס שטייט אויף אייער העלט פלאן ID קארטל , דרוקט 0. TTY 711
63. Yoruba	O ní ẹtọ lati rí iranwọ àti ìfitónilétí gbà ní èdè rẹ láìsanwó. Láti bá ògbufọ kan sọrọ, pè sórí nọmbà ẹrọ ibánisọrọ láisanwó ibodè ti a tò sóri kádi idánimọ ti ètò ilera rẹ, tẹ '0'. TTY 711

ADDENDUM – REAL APPEAL

This Addendum to the Plan provides Benefits for virtual obesity counseling services for eligible Covered Persons through Real Appeal. There are no deductibles, Copayments or Coinsurance you must meet or pay for when receiving these services.

Real Appeal

The Plan provides a virtual lifestyle intervention for weight-related conditions to eligible Covered Persons 18 years of age or older. Real Appeal is designed to help those at risk from obesity-related diseases.

This intensive, multi-component behavioral intervention provides 52 weeks of support. This support includes one-on-one coaching with a live virtual coach and online group participation with supporting video content. The experience will be personalized for each individual through an introductory online session.

These Covered Health Services will be individualized and may include, but is not limited to, the following:

- Virtual support and self-help tools: Personal one-on-one coaching, group support sessions, educational videos, tailored kits, integrated web platform and mobile applications.
- Education and training materials focused on goal setting, problem-solving skills, barriers and strategies to maintain changes.
- Behavioral change counseling by a specially trained coach for clinical weight loss.

If you would like information regarding these Covered Health Services, you may contact the Claims Administrator through **www.realappeal.com**, or at the number shown on your ID card.