



MAMSI Life and Health Insurance Company
MD-Individual Practice Association, Inc.
Optimum Choice, Inc.
UnitedHealthcare Insurance Company
UnitedHealthcare of the Mid-Atlantic, Inc.

Maryland Continuity of Health Care Notice

You are receiving this notice because you are a new enrollee and may be moving from Maryland Medical Assistance or another company's health benefit plan or dental plan to UnitedHealthcare coverage under one of the licensed entities listed above.

If you currently are receiving treatment you have special rights in Maryland. For example, if your old company gave you pre-approval to have surgery or to receive other services, you may not need to receive new approval from us to proceed with the surgery or to continue receiving the same services. Also, if you are seeing a doctor or other health care provider who is an in-network provider with your old company, and that provider is not an in-network provider under your new plan, you may continue to see your provider for a limited period of time as though the provider were an in-network provider with us.

The rules on how you can qualify for these special rights are described below.

Prior approval for health care or dental services.

- If you previously were covered under another company's plan, a prior approval (also called "preauthorization") for services that you received under your old plan may be used to satisfy a prior approval requirement for those services if they are covered under your new plan with us.
- **To be able to use the old prior approval under this new plan, you will need to contact us by calling the member number listed on your ID card to let us know that you have a prior approval for the services and provide us with a copy of the prior approval.** Your parent, guardian, designee, or health care provider may also contact us on your behalf about the prior approval.
- There is a time limit for how long you can rely on the prior approval. For all conditions other than pregnancy, the time limit is 90 days or until the course of treatment is completed, whichever is sooner. The 90-day limit is measured from the date your coverage starts under the new plan. For pregnancy, the time limit lasts through the pregnancy and the first visit to a health care practitioner after the baby is born.
- *Limitation on Use of Prior Approvals:* If your prior approval was for benefits or services provided through the Maryland Medical Assistance fee-for-service program, you may not use the prior approval unless it is for behavioral health or dental benefits authorized by a third-party administrator.

If you do not have a copy of the prior approval, contact your old company and request a copy. Under Maryland law, your old company must provide a copy of the prior approval within 10 days of your request.

Right to use non-network providers.

- If you have been receiving services from a health care provider who was an in-network provider with your old company, and that provider is a non-network provider under your new health plan with us, you may be able to continue to see your provider as though the provider were an in-network provider. You must contact us by calling the member number listed on your ID card to request the right to continue to see the non-network provider as if the provider were an in-network provider with us. Your parent, guardian, designee, or health care provider may also contact us on your behalf to request the right for you to continue to see the non-network provider.
- This right applies only if you are being treated by the non-network provider for covered services for one or more of the following types of conditions:
 1. Acute conditions (including acute dental conditions);
 2. Serious chronic conditions (including serious chronic dental conditions);
 3. Pregnancy;
 4. Mental health conditions;
 5. Substance use disorders; or
 6. Any other condition upon which we and the out-of-network provider agree.

- Examples of the conditions listed above include bone fractures, joint replacements, heart attacks, cancer, HIV/AIDS and organ transplants.
- There is a time limit for how long you can continue to see a non-network provider and only need to pay cost-sharing as though the provider were an in-network provider. For all conditions other than pregnancy, the time limit is 90 days or until the course of treatment is completed, whichever is sooner. The 90-day limit is measured from the date your coverage starts under the new plan. For pregnancy, the time limit lasts through the pregnancy and the first visit to a health care practitioner after the baby is born.

Example of how the right to use non-network providers works: *[Examples are not required for stand-alone dental plans or stand-alone dental insurance]*

[Example for enrollees with HMO plans] You broke your arm while covered under Company A's health plan and saw a Company A network doctor to set your arm. You changed health plans and are now covered under Company B's HMO plan. Your doctor is not a network provider with Company B. You now need to have the cast removed and want to see the original doctor who put on the cast.

In this example, you or your representative need to contact Company B so that Company B can pay your claim as if you are still receiving care from a network doctor. Your non-network provider is not permitted to bill you for any amount other than a deductible, copayment or coinsurance. Your non-network provider is not permitted to bill you the difference between what the doctor normally charges and the amount that the HMO determines to be the allowable amount.

[Example for enrollees with PPO plans] You broke your arm while covered under Company A's health plan and saw a Company A network doctor to set your arm. You changed health plans and are now covered under Company B's plan. Your doctor is not a network provider with Company B. You now need to have the cast removed and want to see the original doctor who put on the cast.

In this example, you or your representative need to contact Company B so that Company B can pay your claim as if you are still receiving care from a network doctor. If the non-network doctor accepts Company B's rate of payment, the doctor is only permitted to bill you for the in-network cost-sharing amounts that apply to the service, such as copayments, coinsurance and deductible.

In this example, if the non-network doctor will *not* accept Company B's rate of payment, the doctor may decide *not* to provide services to you, or may continue to provide services to you and bill you not only for any copayment, coinsurance or deductible that applies, but also bill you for the difference between the doctor's fee and the allowable charge determined by Company B.

Limitation: With regard to dental benefits, the special rights described in this notice apply only to covered services for which a coordinated treatment plan is in progress.

Appeal Rights:

- If we deny your right to use a prior approval from your old company or your right to continue to see a provider who was an in-network provider with your old company, you may appeal this denial by contacting us by calling the member number listed on your ID card.
- If we deny your appeal, you may file a complaint with the Maryland Insurance Administration. To receive a complaint form from the Maryland Insurance Administration call 1-800-492-6116, select option 3, then option 2 or download a complaint form from the Maryland Insurance Administration's website at www.mdinsurance.state.md.us.
- If you have any questions about this notice, please contact us by calling the member number listed on your ID card.