Optimum Choice, Inc.

Individual Exchange Medical Policy

Agreement and Consideration

We will pay Benefits as set forth in this Policy. This Policy is issued in exchange for and on the basis of the statements made on your application and payment of the first Premium. It takes effect on the effective date shown above. Coverage will remain in force until the first Premium due date, and for such further periods for which Premium payment is received by us when due, subject to the renewal provision below. Coverage will begin at 12:01 a.m. and end at 12:00 midnight in the time zone where you live.

Guaranteed Renewable Subject to Listed Conditions

You may keep coverage in force by timely payment of the required Premiums under this Policy, except that your coverage may end for events as described in *Section 4: When Coverage Ends*, under *Events Ending Your Coverage* and *Other Events Ending Your Coverage*.

This Policy will renew on January 1 of each calendar year. On January 1st, we may make modifications in coverage if such modifications are made on a uniform basis for all individuals with the same product and we provide written notice of the modification prior to the next open enrollment period. In addition, we may make modifications at any time if the modification is directly related to a State or Federal requirement and the modification is made within a reasonable time period after the State or Federal requirement is imposed or modified.

On January 1 of each calendar year, we may change the rate table used for this Policy form. Each Premium will be based on the rate table in effect on that Premium's due date. Some of the factors used in determining your Premium rates are the Policy plan, type and level of Benefits and place of residence on the Premium due date and age of Covered Persons as of the effective date or renewal date of coverage. Premium rates are expected to increase over time.

A 45 day notice will be mailed to you at your last address, as shown in our records, prior to any plan to take an action or make a change permitted by this clause.

Nothing in this section requires us to renew or continue coverage for which your continued eligibility would otherwise be prohibited under applicable law.

10-Day Right to Examine and Return this Policy

Please read this Policy. If you are not satisfied, you may notify us within 10 days after you received it. Any Premium paid will be refunded, less claims paid. This Policy will then be void from its start.

This Policy is signed for us as of the effective date as shown above.

Optimum Choice, Inc.

Joseph Ochipinti, President and CEO

What Is the Policy?

This Policy is a legal document between Optimum Choice, Inc. and you and describes Covered Health Care Services, subject to the terms, conditions, exclusions and limitations of this Policy. We issue this Policy based on the Policyholder's *Application* and payment of the required Premium.

This Policy includes:

- The *Schedule of Benefits*.
- The Policyholder's *Application*.
- Riders.
- Amendments.

This Policy is not a Medicare supplement policy. It is not designed to fill the “gaps” of Medicare. If you are eligible for Medicare, review the Medicare supplement buyer’s guide available from the company.

Can This Policy Change?

We may, from time to time, change this Policy by attaching legal documents called *Riders* and/or *Amendments* that may change certain provisions of this Policy. When this happens we will send you a new Policy, *Rider* or *Amendment*.

A change in the Policy is not valid:

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

Other Information You Should Have

We have the right to change, interpret, withdraw or add Benefits, or to end this *Policy*, as permitted by law.

This Policy will remain in effect as long as the Premium is paid when due, subject to the renewal and termination provisions of this Policy.

We are delivering this Policy in Maryland. This Policy is governed by Maryland law.

Introduction to Your Policy

This Policy describes your Benefits, as well as your rights and responsibilities, under this Policy.

What Are Defined Terms?

Certain capitalized words have special meanings. We have defined these words in *Section 8: Defined Terms*.

When we use the words "we," "us," and "our" in this document, we are referring to Optimum Choice, Inc. When we use the words "you" and "your," we are referring to people who are Covered Persons, as that term is defined in *Section 8: Defined Terms*.

How Do You Use This Document?

Read your entire Policy and any attached Riders and/or Amendments. You may not have all of the information you need by reading just one section. Keep your *Policy* and *Schedule of Benefits* and any attachments in a safe place for your future reference. You can also get this Policy at www.myuhc.com/exchange.

Review the Benefit limitations of this Policy by reading the attached *Schedule of Benefits* along with *Section 1: Covered Health Care Services* and *Section 2: Exclusions and Limitations*. Read *Section 7: General Legal Provisions* to understand how this Policy and your Benefits work. Call us if you have questions about the limits of the coverage available to you.

If there is a conflict between this *Policy* and any summaries provided to you, this *Policy* controls.

Please be aware that your Physician is not responsible for knowing or communicating your Benefits.

How Do You Contact Us?

Call the telephone number listed on your ID card. Throughout the document you will find statements that encourage you to contact us for more information.

Your Responsibilities

Enrollment and Required Premiums

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

- Your enrollment must be in accordance with the requirements of this Policy, including the eligibility requirements.
- You must qualify as a Policyholder or a Dependent as those terms are defined in *Section 8: Defined Terms*.
- You must pay Premium as required.

Be Aware the Policy Does Not Pay for All Health Care Services

This Policy does not pay for all health care services. Benefits are limited to Covered Health Care Services. The *Schedule of Benefits* will tell you the portion you must pay for Covered Health Care Services.

Decide What Services You Should Receive

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

Choose Your Physician

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

Obtain Prior Authorization

Some Covered Health Care Services require prior authorization. Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. For detailed information on the Covered Health Care Services that require prior authorization, please refer to the *Schedule of Benefits*.

Pay Your Share

You must meet any applicable deductible and pay a Co-payment and/or Co-insurance for most Covered Health Care Services. These payments are due at the time of service or when billed by the Physician, provider or facility. Any applicable deductible, Co-payment and Co-insurance amounts are listed in the *Schedule of Benefits*.

Pay the Cost of Excluded Services

You must pay the cost of all excluded services and items. Review *Section 2: Exclusions and Limitations* to become familiar with this Policy's exclusions.

Show Your ID Card

You should show your ID card every time you request health care services. If you do not show your ID card, the provider may fail to bill the correct entity for the services delivered. However, if you forget your ID card, it may cause a delay in obtaining Benefits, but does not eliminate the ability to obtain Benefits.

File Claims with Complete and Accurate Information

When you receive Covered Health Care Services from an Out-of-Network Provider, as a result of an Emergency or we refer you to an Out-of-Network Provider you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described in *Section 5: How to File a Claim*.

Use Your Prior Health Care Coverage

If you have prior coverage that, as required by state law, extends benefits for a particular condition or a disability, we will not pay Benefits for health care services for that condition or disability until the prior coverage ends. We will pay Benefits as of the day your coverage begins under this Policy for all other Covered Health Care Services that are not related to the condition or disability for which you have other coverage.

Our Responsibilities

Determine Benefits

We do not make decisions about the kind of care you should or should not receive. You and your providers must make those treatment decisions.

We will determine the following:

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

We may assign this authority to other persons or entities that may provide administrative services for this Policy, such as claims processing. The identity of the service providers and the nature of their services may be changed from time to time as we determine. In order to receive Benefits, you must cooperate with those service providers.

Pay for Our Portion of the Cost of Covered Health Care Services

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

Pay Network Providers

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

Pay for Covered Health Care Services Provided by Out-of-Network Providers

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

Review and Determine Benefits in Accordance with our Reimbursement Policies

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

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

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), our reimbursement policies are applied to provider billings. We share our reimbursement policies with Physicians and other providers in our Network through our provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. However, Out-of-Network Providers may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed; this provision does not apply to an on-call Physician, a Hospital-based Physician, or an ambulance service provider as defined under Maryland law, who has accepted an assignment of Benefits. An on-call Physician, Hospital-based Physician, or ambulance service provider as defined under Maryland law, who has accepted an assignment of Benefits will be paid in accordance with the payment methodology as required.

We may refuse to directly reimburse an Out-of-Network Provider under an assignment of Benefits if:

- We receive notice of the assignment of benefits after the time we have paid benefits to you;
- Due to an inadvertent administrative error, we have previously paid you;

- You withdraw assignment of benefits before we have paid benefits to the Out-of-Network Provider; or
- You paid the Out-of-Network Provider the full amount due at the time of service.

You may get copies of our reimbursement policies for yourself or to share with your out-of-Network Physician or provider at the telephone number on your ID card.

We 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, we will use a comparable methodology(ies). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at www.myuhc.com/exchange for information regarding the vendor that provides the applicable methodology.

Offer Health Education Services to You

We may provide you with access to information about additional services that are available to you, such as disease management programs, health education and patient advocacy. It is solely your decision whether to take part in the programs, but we recommend that you discuss them with your Physician.

Optimum Choice, Inc.

Individual Exchange Medical Policy

10175 Little Patuxent Parkway, 6th Floor

Columbia, MD 21044

(800) 691-0021

Policy Number - [999-999-999]

Policyholder - [John Doe]

Effective Date - [Month Day, Year]

Total Premium - [$XXXX.XX]

Premium Mode - [Monthly] [Quarterly]

Your *Schedule of Benefits* and *Policy* are provided in the pages that follow.

UnitedHealthcare Individual Exchange

Optimum Choice, Inc.

Schedule of Benefits

Covered Health Care Services Schedule of Benefits

UHC Silver-X Value Plan

MD0025X, $4,500

How Do You Access Benefits?

Selecting a Network Primary Care Physician

You must select a Network Primary Care Physician, who is located in the Network Area, in order to obtain Benefits. In general health care terminology, a Primary Care Physician may also be referred to as a *PCP.* A Network Primary Care Physician will be able to coordinate all Covered Health Care Services and submit electronic referrals online to UnitedHealthcare for services from Network Physicians. If you are the custodial parent of an Enrolled Dependent child, you must select a Network Primary Care Physician who is located in the Network Area, for that child. If you do not select a Network Primary Care Physician for yourself or your Enrolled Dependent child, one will be assigned.

You may select any Network Primary Care Physician, who is located in the Network Area, accepting new patients. You may designate a Network Physician who specializes in pediatrics (including pediatric subspecialties, based on the scope of that provider's license under applicable state law) as the Network Primary Care Physician for an Enrolled Dependent child. For obstetrical or gynecological care, you do not need a referral from a Network Primary Care Physician and may seek care directly from any Network Physician who specializes in obstetrics or gynecology.

You can get a list of Network Primary Care Physicians, Network obstetricians and gynecologists and other Network providers through www.myuhc.com/exchange or the telephone number on your ID card.

You may change your Network Primary Care Physician by calling the telephone number shown on your ID card or by going to www.myuhc.com/exchange. Changes are permitted once per month. Changes submitted on or before the last day of the month will be effective on the first day of the following month.

Standing Referrals to a Network Specialist Physician

You may obtain a standing referral to a Network Specialist Physician under the following circumstances:

- You have a condition or disease that is life threatening, degenerative, chronic, or disabling and requires specialized medical care; and
- The Specialist Physician is a Network Physician and has expertise in treating the life-threatening, degenerative, chronic, or disabling disease or condition.
- The standing referral will be made in accordance with a written treatment plan for Covered Health Care Services by the Primary Care Physician, the Specialist Physician and the Covered Person. Such treatment plan may limit the number of visits to the Specialist Physician, limit the period of time in which visits to the Specialist Physician are authorized, and require the Specialist Physician to communicate regularly with the Primary Care Physician regarding the Covered Person's treatment and health status.

Network and Out-of-Network Benefits

To obtain Benefits, you must receive Covered Health Care Services from a UnitedHealthcare Individual Exchange Network provider. You can confirm that your provider is a UnitedHealthcare Individual Exchange Network provider through the telephone number on your ID card or you can access a directory of providers at www.myuhc.com/exchange. You should confirm that your provider is a UnitedHealthcare Individual Exchange Network provider.

Except as specifically described in this *Schedule of Benefits*, Benefits are not available for services provided by Out-of-Network Providers. This Benefit plan does not provide an out-of-Network level of Benefits. However, Benefits are provided when Covered Health Care Services are received from an Out-of-Network Provider as a result of an Emergency at an Urgent Care Center outside your geographic area, or if a Covered Health Care Service received by an Out-of-Network Provider was preauthorized or otherwise approved by us or a Network provider, or obtained pursuant to a verbal or written by us or a Network provider.

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

Emergency Health Care Services provided by an Out-of-Network Provider will be reimbursed as set forth under *Allowed Amounts* as described at the end of this *Schedule of Benefits*.

Covered Health Care Services provided at certain Network facilities by an out-of-Network Physician, when not Emergency Health Care Services, will be reimbursed as set forth under *Allowed Amounts* as described at the end of this *Schedule of Benefits*. For these Covered Health Care Services, "certain Network facility" is limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

Ground and Air Ambulance transport provided by an Out-of-Network Provider will be reimbursed as set forth under *Allowed Amounts* as described at the end of this *Schedule of Benefits.*

You must show your identification card (ID card) or give correct insurance information every time you request health care services from a Network provider. If you do not show your ID card or give correct insurance information, Network providers have no way of knowing that you are enrolled under a UnitedHealthcare Policy and the provider may fail to bill the correct entity for services delivered. If you forget your ID card, it may cause a delay in obtaining Benefits but does not eliminate the ability to obtain Benefits.

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

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

Care Management

There may be additional services that are available to you, such as disease management programs, discharge planning, health education, and patient advocacy. When you seek prior authorization for a Covered Health Care Service as required or are otherwise identified as meeting eligibility requirements for a care management program, we will work with you to engage in the care management process and to provide you with information about these additional services.

Does Prior Authorization Apply

We require prior authorization for certain Covered Health Care Services. Your Primary Care Physician and other Network providers are responsible for obtaining prior authorization before they provide these services to you.

Please note that prior authorization is required even if you have an electronic referral submitted online to UnitedHealthcare by your Primary Care Physician to seek care from another Network Physician.

What Will You Pay for Covered Health Care Services?

Benefits for Covered Health Care Services are described in the tables below.

Payment Information

Annual Deductibles are calculated on a calendar year basis.

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

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

NOTE: When Covered Health Care Services are provided by an Indian Health Service provider, your cost share may be reduced.

Payment Term And Description	Amounts
Annual Deductible	
The amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits. The Annual Deductible applies to Covered Health Care Services under the Policy as indicated in this *Schedule of Benefits* including Covered Health Care Services provided under [4]the *Pediatric Vision Care Services Section* and the *Pediatric Dental Care Services Section*. Benefits for outpatient prescription drugs on the PPACA Zero Cost Share Preventive Care Medications are not subject to payment of the Annual Deductible. Amounts paid toward the Annual Deductible for Covered Health Care Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of the Allowed Amount or the Recognized Amount when applicable. The Annual Deductible does not include any amount that exceeds the Allowed Amount. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.	$4,500 per Covered Person, not to exceed $9,000 for all Covered Persons in a family.
Out-of-Pocket Limit	
The maximum you pay per year for the Annual Deductible, Co-payments or Co-insurance. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year. The Out-of-Pocket Limit applies to Covered Health Care Services under the Policy as indicated in this Schedule of Benefits including the *Pediatric Dental Care Services Section* and the *Pediatric Vision Care Services Section*. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Limit does not include any of the following and, once the Out-of-Pocket Limit has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Care Services. • Charges that exceed Allowed Amounts, when applicable.	$7,600 per Covered Person, not to exceed $15,200 for all Covered Persons in a family. The Out-of-Pocket Limit includes the Annual Deductible.
Co-payment	
Co-payment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Care Services. When Co-payments apply, the amount is listed on the following pages next to the description for each Covered Health Care Service. Please note that for Covered Health Care Services, you are responsible for paying the lesser of: • The applicable Co-payment. • The Allowed Amount or the Recognized Amount when applicable. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.	

Payment Term And Description	Amounts
Co-insurance	
Co-insurance is the amount you pay (calculated as a percentage of the Allowed Amount or the Recognized Amount when applicable) each time you receive certain Covered Health Care Services. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.	

Schedule of Benefits Table

Note: Your Primary Care Physician must submit an electronic referral before services are rendered by a Network Specialist or other Network Physician in order for benefits to be payable under this Policy.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the Policy, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
1. Acupuncture			
	30%	Yes	Yes
2. Ambulance Services			
Emergency Ambulance Services Allowed Amounts for ground and Air Ambulance transport provided by an Out-of-Network Provider will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*.	*Ground Ambulance:* $350 per transport	Yes	No
	Air Ambulance: $350 per transport	Yes	No
Non-Emergency Ambulance Transportation Ground or Air Ambulance, as we determine appropriate.	*Ground Ambulance:* $350 per transport	Yes	No
Allowed Amounts for Air Ambulance transport provided by an Out-of-Network Provider will be determined as described below under Allowed	*Air Ambulance:* $350 per transport	Yes	No

Note: Your Primary Care Physician must submit an electronic referral before services are rendered by a Network Specialist or other Network Physician in order for benefits to be payable under this Policy.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the Policy, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Amounts in this *Schedule of Benefits.*			
3. Clinical Trials			
Depending upon the Covered Health Care Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.*	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		
4. Dental Anesthesia			
	30%	Yes	Yes
5. Dental Services - Accident Only			
	30%	Yes	Yes
6. Diabetes Services			
Diabetes Self-Management and Educational Services For Covered Persons with Type 1 or Type 2 diabetes, the following services are offered at $0 cost share: • Retinal eye exams, limited to 1 exam per plan year. • Certain lab tests specifically used to assess lipid levels, kidney function (including metabolic and urine) and glucose control (HgbA1C) in diabetics. This does not apply to Covered Persons with pre-	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management and training/diabetic eye exams/foot care will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		

Note: Your Primary Care Physician must submit an electronic referral before services are rendered by a Network Specialist or other Network Physician in order for benefits to be payable under this Policy.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the Policy, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
diabetes or gestational diabetes diagnoses.			
Diabetes Self-Management Supplies Benefits for diabetes equipment that meets the definition of DME are subject to the limit stated under *Durable Medical Equipment (DME)*.	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management supplies will be the same as those stated under *Durable Medical Equipment (DME)* and in the *Outpatient Prescription Drugs* section. Benefits for diabetes supplies will be the same as those stated in the *Outpatient Prescription Drugs* section.		
7. Durable Medical Equipment (DME)			
You must purchase or rent the DME from the vendor we identify or purchase it directly from the prescribing Network Physician.	30%	Yes	Yes
8. Emergency Health Care Services - Outpatient			
Note: If you are confined in an out-of-Network Hospital after you receive outpatient Emergency Health Care Services, you must notify us within one business day or on the same day of admission if reasonably possible. We may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the out-of-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. If you are admitted as an inpatient to a Hospital directly from Emergent ER	$500 per visit	Yes	Yes

Note: Your Primary Care Physician must submit an electronic referral before services are rendered by a Network Specialist or other Network Physician in order for benefits to be payable under this Policy.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the Policy, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Services, the Benefits provided as described under *Hospital - Inpatient Stay* will apply. You will not have to pay the Emergency Health Care Services Co-payment, Co-insurance and/or deductible. Allowed Amounts for Emergency Health Care Services provided by an Out-of-Network Provider will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits.* Amounts paid toward the deductible or Out-of-Pocket Limit for Emergency Health Care Services provided by an Out-of-Network Provider will count towards any applicable deductibles and Out-of-Pocket Limits for Emergency Health Care Services provided by a Network Provider.			
9. Enteral Nutrition			
	30%	Yes	Yes
10. Habilitative Services			
	Inpatient Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
	Outpatient $35 per visit	Yes	No
11. Hearing Aids			

Note: Your Primary Care Physician must submit an electronic referral before services are rendered by a Network Specialist or other Network Physician in order for benefits to be payable under this Policy.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the Policy, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Benefits are limited to a single purchase per hearing impaired ear every 36 months.	30%	Yes	Yes
12. Home Health Care			
For the administration of intravenous infusion, you must receive services from a provider we identify. Note: Home Health Care visits that are provided according to the benefit described in *Section 1, Pregnancy-Maternity Services* in the Policy are not subject to deductible and Co-insurance.	30%	Yes	Yes
13. Hospice Care			
Limited to: • 30 days inpatient hospice. • 14 days respite care per year. • 6 months or 15 visits, whichever comes first, for bereavement counseling visits.	30%	Yes	Yes
14. Hospital - Inpatient Stay			
	$550 per Inpatient Stay	Yes	Yes
15. Infertility Services			
Limited to 3 attempts of artificial insemination over the course of one year.	30%	Yes	Yes

Note: Your Primary Care Physician must submit an electronic referral before services are rendered by a Network Specialist or other Network Physician in order for benefits to be payable under this Policy.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the Policy, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
16. Lab, X-Ray and Diagnostics - Outpatient Diagnostic and supplemental breast examinations and follow-up diagnostic imaging for lung cancer are not subject to any Co-payment or Co-insurance.			
Lab Testing - Outpatient: Limited to 18 Presumptive Drug Tests per year. Limited to 18 Definitive Drug Tests per year.	$80 at a freestanding lab or in a Physician's office	Yes	No
	$80 at a Hospital-based lab	Yes	No
X-Ray and Other Diagnostic Testing - Outpatient:	$150 at a freestanding diagnostic center or in a Physician's office	Yes	No
	$150 at an outpatient Hospital-based diagnostic center	Yes	No
17. Major Diagnostic and Imaging - Outpatient			
	$600 at a freestanding diagnostic center or in a Physician's office	Yes	Yes
	$600 at an outpatient Hospital-based diagnostic center	Yes	Yes
18. Manipulative Treatment			
Limited to 20 manipulative therapy services visits per condition per year	30%	Yes	Yes
19. Medical Homes			
	$35	Yes	No
20. Mental Health Care and Substance-Related and			

Note: Your Primary Care Physician must submit an electronic referral before services are rendered by a Network Specialist or other Network Physician in order for benefits to be payable under this Policy.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the Policy, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Addictive Disorders Services			
	Inpatient $550 per Inpatient Stay	Yes	Yes
	Outpatient $35 for Partial Hospitalization/ Intensive Outpatient Treatment/Intensive Behavioral Therapy *Office Visit* $35 per visit	Yes Yes	No No
21. Morbid Obesity Surgery			
Morbid Obesity surgery must be received from a Designated Provider.	$150 per surgery	Yes	Yes
22. Necessary Medical Supplies			
	30%	Yes	Yes
23. Orthotics			
	30%	Yes	Yes
24. Pharmaceutical Products - Outpatient			
Pharmaceutical Products which, due to their traits (as determined by us), are administered or directly supervised by a qualified provider or licensed/certified health professional. **Note**: Benefits for medication normally	30%	Yes	Yes

Note: Your Primary Care Physician must submit an electronic referral before services are rendered by a Network Specialist or other Network Physician in order for benefits to be payable under this Policy.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the Policy, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
available by a prescription or order or refill are provided as described under your *Outpatient Prescription Drug Section*.			
25. Physician Fees for Surgical and Medical Services			
Allowed Amounts for Covered Health Care Services provided by an out-of-Network Physician in certain Network facilities will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*.	30% at a Hospital $150 at a Physician's office $150 at an outpatient Hospital-based center	Yes	Yes Yes Yes
26. Physician's Office Services - Sickness and Injury			
	$35 for services provided by your Primary Care Physician $90 for services provided by a Network Specialist or other Network Physician 30% for services provided by a health care practitioner	Yes Yes Yes	No No Yes
27. Pregnancy - Maternity Services			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay and the mother is a Covered Person.		

Note: Your Primary Care Physician must submit an electronic referral before services are rendered by a Network Specialist or other Network Physician in order for benefits to be payable under this Policy.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the Policy, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
28. Preventive Care Services			
Physician office services	None	Yes	No
Lab, X-ray or other preventive tests	None	Yes	No
Breast pumps	None	Yes	No
29. Prosthetic Devices			
	30%	Yes	Yes
30. Reconstructive Procedures			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		
31. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • 30 visits of physical therapy per condition per year. • 30 visits of occupational therapy per condition per year. • 30 visits of speech therapy per condition per year. • 90 visits of cardiac rehabilitation therapy. • One program per Covered Person during the entire period of time he or she is enrolled for coverage under the	$35 per visit	Yes	No

Note: Your Primary Care Physician must submit an electronic referral before services are rendered by a Network Specialist or other Network Physician in order for benefits to be payable under this Policy.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the Policy, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Policy for pulmonary rehabilitation therapy.			
32. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	30%	Yes	Yes
33. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Admissions to a Skilled Nursing Facility are limited to 100 days per year. Inpatient services limited per year as follows: • Any combination of Skilled Nursing or IP Rehab Services.	$150 per Inpatient Stay	Yes	Yes
34. Surgery - Outpatient			
	$150 per surgery	Yes	Yes
35. Telehealth			
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		
36. Temporomandibular Joint Syndrome (TMJ)			
	30%	Yes	Yes
37. Therapeutic Treatments - Outpatient			
	30%	Yes	Yes
38. Transplantation Services			

Note: Your Primary Care Physician must submit an electronic referral before services are rendered by a Network Specialist or other Network Physician in order for benefits to be payable under this Policy.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the Policy, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Transplantation services must be received from a Designated Provider.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*		
39. Urgent Care Center Services			
Co-payment/Co-insurance and any deductible for the following services also apply when the Covered Health Care Service is performed at an Urgent Care Center: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostic - Outpatient.* • Major diagnostic and nuclear medicine described under *Major Diagnostic and Imaging - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient*. • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*. • Outpatient surgery procedures described under *Surgery - Outpatient*. • Outpatient therapeutic procedures described	$75 per visit	Yes	No

Note: Your Primary Care Physician must submit an electronic referral before services are rendered by a Network Specialist or other Network Physician in order for benefits to be payable under this Policy.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the Policy, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
under *Therapeutic Treatments - Outpatient*.			
40. Virtual Care Services			
Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting us at www.myuhc.com/exchange or the telephone number on your ID card.	*Primary Care* $35 per visit	Yes	No
	Urgent Care $35 per visit	Yes	No

Allowed Amounts

Allowed Amounts are the amount we determine that we will pay for Benefits.

- For Network Benefits for Covered Health Care Services provided by a Network provider, except for your cost sharing obligations, you are not responsible for any difference between Allowed Amounts and the amount the provider bills.
- For Covered Health Care Services that are ***Ancillary Services received at certain Network facilities on a non-Emergency basis from out-of-Network Physicians****, you* are not responsible, and the Out-of-Network Provider should not bill you, for amounts in excess of your Co-payment, Co-insurance or deductible which is based on the Recognized Amount as defined in this *Policy*. We will make payment for the Covered Health Care Service directly to the Out-of-Network Provider, and the payment amount will be equal to the amount by which the Out-of-Network Rate exceeds the cost-sharing amount for the services.
- For Covered Health Care Services that are ***non-Ancillary Services received at certain Network facilities on a non-Emergency basis from out-of-Network Physicians who have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a non-Ancillary Service is provided for which notice and consent has been satisfied as described below****, you* are not responsible, and the Out-of-Network Provider should not bill you, for amounts in excess of your Co-payment, Co-insurance or deductible which is based on the Recognized Amount as defined in this *Policy.* We will make payment for the Covered Health Care Service directly to the Out-of-Network Provider, and the payment amount will be equal to the amount by which the Out-of-Network Rate exceeds the cost-sharing amount for the services.
- For Covered Health Care Services that are ***Emergency Health Care Services or Urgent Care Center services provided by an Out-of-Network Provider***, you are not responsible, and the Out-of-Network Provider should not bill you, for amounts in excess of your applicable Co-payment, Co-insurance or deductible which is based on the Recognized Amount as defined in this *Policy.* We will make payment for the covered Emergency Health Care Services directly to the Out-of-Network Provider or Out-of-Network Emergency Facility.

- For Covered Health Care Services that are ***Air Ambulance services provided by an Out-of-Network Provider***, you are not responsible, and the Out-of-Network Provider should not bill you, for amounts in excess of your applicable Co-payment, Co-insurance or deductible which is based on the rates that would apply if the service was provided by a Network provider which is based on the lesser of the Qualified Payment Amount as defined in the *Policy* or the billed amount for the services. We will make payment for the covered Air Ambulance services directly to the Out-of-Network Provider. The payment amount will be equal to the amount by which Out-of-Network Rate exceeds the cost-sharing amount for the services.

Allowed Amounts are determined in accordance with our reimbursement policy guidelines or as required by law, as described in this *Policy*.

For Network Benefits, Allowed Amounts are based on the following:

- When Covered Health Care Services are received from a Network provider, Allowed Amounts are our contracted fee(s) with that provider.
- When Covered Health Care Services are received from an Out-of-Network Provider as arranged by us, including when there is no Network provider who is reasonably accessible or available to provide Covered Health Care Services, Allowed Amounts are an amount negotiated by us or an amount permitted by law. Please contact us if you are billed for amounts in excess of your applicable Co-insurance, Co-payment or any deductible. We will not pay excessive charges or amounts you are not legally obligated to pay.

When Covered Health Care Services are received from an Out-of-Network Provider as described below, Allowed Amounts are determined as follows:

For non-Emergency Covered Health Care Services received at certain Network facilities from out-of-Network Physicians when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Health Service Ac*t with respect to a Visit as defined by the Secretary (including non-Ancillary Services that have satisfied the notice and consent criteria but unforeseen, urgent medical needs arise at the time the services are provided), the Allowed Amount is based on one of the following in the order listed below as applicable:

- The reimbursement rate as determined by a state *All Payer Model Agreement.*
- The reimbursement rate as determined by state law.
- The initial payment made by us, or the amount subsequently agreed to by the Out-of-Network Provider and us.
- The amount determined by *Independent Dispute Resolution (IDR).*

For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

IMPORTANT NOTICE: For Ancillary Services, non-Ancillary Services provided without notice and consent, and non-Ancillary Services for unforeseen or urgent medical needs that arise at the time a service is provided for which notice and consent has been satisfied, you are not responsible, and an out-of-Network Physician or out-of-Network non-Physician should not bill you, for amounts in excess of your applicable Co-payment, Co-insurance or deductible which is based on the Recognized Amount as defined in the *Policy*.

For Emergency Health Care Services or Urgent Care Center services provided by an Out-of-Network Provider, the Allowed Amount is based on one of the following in the order listed below as applicable:

- The reimbursement rate as determined by a state *All Payer Model Agreement.*
- The reimbursement rate as determined by state law.
- The initial payment made by us, or the amount subsequently agreed to by the Out-of-Network Provider and us.
- The amount determined by *Independent Dispute Resolution (IDR).*

IMPORTANT NOTICE: You are not responsible, and an Out-of-Network Provider should not bill you, for amounts in excess of your applicable Co-payment, Co-insurance or deductible which is based on the Recognized Amount as defined in the *Policy.*

For Air Ambulance transportation provided by an Out-of-Network Provider, the Allowed Amount is based on one of the following in the order listed below as applicable:

- The reimbursement rate as determined by a state *All Payer Model Agreement*.
- The reimbursement rate as determined by state law.
- The initial payment made by us, or the amount subsequently agreed to by the Out-of-Network Provider and us.
- The amount determined by *Independent Dispute Resolution (IDR).*

IMPORTANT NOTICE: You are not responsible, and an Out-of-Network Provider should not bill you, for amounts in excess of your Co-payment, Co-insurance or deductible which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the *Policy*.

For Emergency ground ambulance transportation provided by an Out-of-Network Provider, the Allowed Amount, which includes mileage, is a rate agreed upon by the Out-of-Network Provider or, unless a different amount is required by applicable law, determined based upon the median amount negotiated with Network providers for the same or similar service.

IMPORTANT NOTICE: Out-of-Network Providers have the right to bill you for any difference between the provider's billed charges and the Allowed Amount described here.

Provider Network

We arrange for health care providers to take part in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to choose your provider.

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

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling the telephone number on your ID card. A directory of providers is available by contacting us at www.myuhc.com/exchange or the telephone number on your ID card to request a copy. If you receive a Covered Health Care Service from an Out-of-Network Provider and were informed incorrectly prior to receipt of the Covered Health Care Service that the provider was a Network provider, either through a database, provider directory, or in a response to your request for such information (via telephone, electronic, web-based or internet-based means), you will be eligible for cost sharing (Co-payment, Co-insurance and applicable deductible) that would be no greater than if the service had been provided from a Network provider. Please refer to the *Cost-sharing and Balance Billing Protections for Services Provided Based on Reliance on Incorrect Provider Network Information* provision below.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Benefits. However, if you are currently receiving treatment for Covered Health Care Services from a provider whose network status changes from Network to out-of-Network during such treatment due to termination (non-renewal or expiration) of the provider's contract, you may be eligible to request continued care from your current provider under the same terms and conditions that would have applied prior to termination of the provider's contract for specified conditions and timeframes. This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud. If you would like help to find out if you are eligible for continuity of care Benefits, please call the telephone number on your ID card or refer to the *Continuity of Care* provision below.

If you are currently undergoing a course of treatment using an out-of-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help to find out if you are eligible for transition of care Benefits, please call the telephone number on your ID card or refer to the *Continuity of Care* provision below.

Do not assume that a Network provider's agreement includes all Covered Health Care Services. Some Network providers contract with us to provide only certain Covered Health Care Services, but not all Covered Health Care Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for help.

Designated Providers

If you require Covered Health Care Services for morbid obesity surgery or transplantation services, we may direct you to a Designated Provider chosen by us. The Designated Provider may be located outside your local geographic area.

Benefits will only be paid if your Covered Health Care Services for that condition are provided by or arranged by the Designated Provider chosen by us.

Your Primary Care Physician or other Network Physician must notify us of your need for morbid obesity surgery or transplantation services that would warrant referral to a Designated Provider. If you receive services from an out-of-Network facility (regardless of whether it is a Designated Provider) or other Out-of-Network Provider without a verbal or written referral by us or a Network Provider, Benefits will not be paid. If a Network Provider knows about the need for a referral and fails to obtain the referral, Benefits will not be denied.

Health Care Services from Out-of-Network Providers

If you are diagnosed with a condition or disease that requires specialized health care services or medical care, including Mental Health Care Services and Substance-Related and Addictive Disorders Services, and such specialized service or care is either not available from a Network provider or access to such a Network Provider would require unreasonably delay or travel, you may be eligible for Network Benefits when Covered Health Care Services are received from Out-of-Network Providers.

In this situation, you may request a referral to an Out-of-Network Provider from your Network Physician and your Network Physician will notify us and, if we confirm that the required specialized service or care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through an Out-of-Network Provider. When coordinated, such service received from an Out-of-Network Provider will be treated as Network Benefits, including any applicable Co-payment, Co-insurance and deductible requirements. Additionally, for Mental Health Care Services and Substance-Related and Addictive Disorders Services, you are not responsible for any difference between Allowed Amounts and the amount the provider bills.

Cost-sharing and Balance Billing Protections for Services Provided Based on Reliance on Incorrect Provider Network Information

If a Covered Person is furnished, by an Out-of-Network Provider, an item or service that would otherwise be covered if provided by a Network Provider, and the Covered Person relied on a database, provider directory, or information regarding the provider's network status provided by us through a telephone call or electronic, web-based, or Internet-based means which incorrectly indicated that the provider was a Network Provider for the furnishing of such item or service, then the following apply:

- The copayment amount, coinsurance percentage, and/or other cost-sharing requirements for such item or service furnished by an Out-of-Network Provider is the same as the copayment amount, coinsurance percentage, and/or other cost-sharing requirement listed in the contract for the item or service when provided by a Network Provider; and
- Any cost-sharing payments made with respect to the item or service will be counted toward any applicable in-network deductible and in-network out-of-pocket maximum.
- The Covered Person will not be liable for an amount that exceeds the cost-sharing that would have applied to the Covered Person if the provider was a Network Provider.

Continuity of Care

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

- The procedures, treatments, medications or services that are Covered Health Care Services under this Policy for the following periods of time:
    - The lesser of the course of treatment or 90 days; and
    - The duration of the three trimesters of a Pregnancy and the initial postpartum visit.

Upon transition from your prior carrier coverage to this Policy, we will allow you to continue prior carrier health care services when they are Covered Health Care Services under this Policy provided by an Out-of-Network Provider for the following conditions:

- Acute conditions;
- Serious chronic conditions;
- Pregnancy;

- Mental Health and Substance-Related and Addictive Disorders Services; and
- Any other condition for which the Out-of-Network Provider and us reach agreement.

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

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

We will pay an Out-of-Network Provider under this provision in accordance with all the applicable requirements of rates and methods of payment under Maryland and federal law including *§19-710.1 of the Maryland Health-General Article*.

Continuing Care Patient

A Continuing Care Patient receiving care from a Network Provider may elect to continue to receive transitional care from such provider if the provider's Network Provider contract is terminated or non-renewed for reasons other than for failure to meet applicable quality standards or for fraud. We will notify each Covered Person who is a Continuing Care Patient at the time of termination or non-renewal on a timely basis of such termination and the Covered Person's right to elect transitional care.

When elected, benefits will be provided under the same terms and conditions as would have applied with respect to items and services that would have been covered had termination not occurred, with respect to the course of treatment provided by such provider or facility relating to the Covered Person's status as a Continuing Care Patient. Benefits will be provided during the period beginning on the date we notify the Continuing Care Patient of the termination and ending on the earlier of: (i) 90 days after the date of such notice; or (ii) the date on which such Covered Person is no longer a Continuing Care Patient with respect to such provider or facility.

The Covered Person will not be liable for an amount that exceeds the cost-sharing that would have applied to the Covered Person had the termination not occurred.

Outpatient Prescription Drugs Schedule of Benefits

When Are Benefits Available for Prescription Drug Products?

Benefits are available for Prescription Drug Products at a Network Pharmacy and are subject to Co-payments and/or Co-insurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is placed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Care Service.

What Happens When a Brand-name Drug Becomes Available as a Generic?

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product can change. Therefore, your Co-payment and/or Co-insurance can change or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

How Do Supply Limits Apply?

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Co-payment and/or Co-insurance, you can receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed. Supply limits are subject, from time to time, to our review and change. This will limit the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or require that a minimum amount be dispensed.

You may find out whether a Prescription Drug Product has a supply limit for dispensing by contacting us at www.myuhc.com/exchange or the telephone number on your ID card.

Do Prior Authorization Requirements Apply?

Before certain Prescription Drug Products are dispensed to you, your prescribing Physician is required to obtain prior authorization from us or our designee. The reason for obtaining prior authorization from us is to determine whether the Prescription Drug Product, in accordance with our approved guidelines, is each of the following:

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

We may also require your prescribing Physician to obtain prior authorization from us or our designee so we can determine whether the Prescription Drug Product, in accordance with our approved guidelines, was prescribed by a Specialist.

If your prescribing Physician does not obtain prior authorization from us before the Prescription Drug Product is dispensed, you will be responsible for paying all charges and no Benefits will be paid. The Prescription Drug Products requiring prior authorization are subject, from time to time, to our review and change. You may find out whether a particular Prescription Drug Product requires notification/prior authorization by contacting us at www.myuhc.com/exchange or the telephone number on your ID card.

If your prescribing Physician does not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You can seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because your prescribing Physician did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Co-payment and/or Co-insurance and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Care Service or it is an Experimental or Investigational or Unproven Service.

We will also require prior authorization for certain programs which will have specific requirements for participation and/or activation of an enhanced level of Benefits related to such programs. You may access information on available

programs and any applicable prior authorization, participation or activation requirements related to such programs by contacting us at www.myuhc.com/exchange or the telephone number on your ID card.

Does Step Therapy Apply?

Certain Prescription Drug Products for which Benefits are described under *Section 10: Outpatient Prescription Drugs* of the Policy are subject to step therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product(s) first.

You may find out whether a Prescription Drug Product is subject to step therapy requirements by contacting us at www.myuhc.com/exchange or the telephone number on your ID card.

Your Right to Request an Exception When a Medication is Not Listed on the Prescription Drug List (PDL)

When a Prescription Drug Product is not listed on the PDL, you or your representative may request an exception to gain access to the excluded Prescription Drug Product. Note that all references to "your representative" include your designee, your prescribing Physician, or other prescriber, as appropriate. To make a request, contact us in writing or call the toll-free number on your ID card. We will make a determination on a standard exception and notify you or your representative of our determination within 72 hours following the receipt of the request.

Please note, if your request for an exception is approved by us, you will be responsible for paying the applicable Co-payment and/or Co-insurance based on the Prescription Drug Product tier placement, or at the second highest tier. For example, if you have a 5-tier plan, then the 4th tier would be considered the second highest tier.

Urgent Requests

If your request requires immediate action and a delay could significantly jeopardize your life, health, or the ability to regain maximum function, or if you are undergoing a course of treatment using a drug that is not on the Prescription Drug List, you or your representative call us as soon as possible. We will provide a written or electronic determination to you or your representative within 24 hours following receipt of the request.

External Review

If you are not satisfied with our determination of your exception request, you or your representative are entitled to request an external review. You or your representative can request an external review by sending a written request to us to the address set out in the determination letter or by calling the toll-free number on your ID card. The *Independent Review Organization* (*IRO*) will notify you or your representative of our determination within 72 hours of receipt of the request.

Expedited External Review

If you are not satisfied with our determination of your exception request and it involves an urgent situation, you or your representative can request an expedited external review by calling the toll-free number on your ID card or by sending a written request to the address set out in the determination letter. The *IRO* will notify you or your representative of our determination within 24 hours following receipt of the request.

What Do You Pay?

You are responsible for paying the Annual Drug Deductible.

Benefits for PPACA Zero Cost Share Preventive Care Medications are not subject to payment of the Annual Drug Deductible.

Benefits for diabetes test strips will be exempt from Co-payment, deductible, and/or Co-insurance.

You can obtain up to twelve cycles of a contraceptive at one time. Each cycle is no less than a one-month supply.

You are responsible for paying the applicable Co-payment and/or Co-insurance described in the *Benefit Information* table. You are not responsible for paying a Co-payment and/or Co-insurance for PPACA Zero Cost Share Preventive Care Medications.

The Co-payment amount or Co-insurance percentage you pay for a Prescription Drug Product will not exceed the Usual and Customary Charge of the Prescription Drug Product.

The amount you pay for any of the following under your Policy will not be included in calculating any Out-of-Pocket Limit stated in your Policy:

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

Payment Information

The Annual Drug Deductibles are calculated on a calendar year basis.

The Out-of-Pocket Drug Limits are calculated on a calendar year basis.

NOTE: When Covered Health Care Services are provided by an Indian Health Service provider, your cost share may be reduced.

Payment Term And Description	Amounts
Annual Drug Deductible	
The amount you pay for covered Tier 1, Tier 2, Tier 3, Tier 4 and Tier 5Prescription Drug Products at a Network Pharmacy in a year before we begin paying for Prescription Drug Products.	$750 per Covered Person, not to exceed $1,500 for all Covered Persons in a family.
Out-of-Pocket Drug Limit	
The maximum amount you are required to pay for covered Prescription Drug Products in a single year. Once you reach the Out-of-Pocket Drug Limit, you will not be required to pay Co-payments or Co-insurance for covered Prescription Drug Products for the remainder of the year.	$1,500 per Covered Person, not to exceed $3,000 for all Covered Persons in a family. The Out-of-Pocket Drug Limit includes the Annual Drug Deductible.
Co-payment and Co-insurance	
Co-payment Co-payment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount. ***Co-insurance*** Co-insurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. **Special Programs:** We will have certain programs in which you may receive a reduced Co-payment and/or Co-insurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You can access information on these programs by contacting us at www.myuhc.com/exchange or the telephone number on your ID card.	For Prescription Drug Products at a Retail or Mail Order Network Pharmacy you are responsible for paying the lowest of the following: • The applicable Co-payment and/or Co-insurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. • The Prescription Drug Charge for that Prescription Drug Product. The Co-payment or Co-insurance you pay for a Prescription Drug Product prescribed to treat diabetes, HIV, or AIDS or a Specialty Prescription Drug Product will not exceed $150 for a 30-day supply. This amount can increase on or after July 1 of each year in accordance with an increase in the consumer price index. The Co-payment or Co-insurance you pay for a covered prescription insulin drug will not exceed $30 for a 30-day supply. You can obtain up to a 90-day supply of insulin products from the Prescription Drug List at a Network Pharmacy for $0 cost to you. You are not responsible for paying a Co-payment and/or Co-insurance for PPACA Zero Cost Share Preventive Care Medications.

Schedule of Benefits Information Table

- Your Co-payment and/or Co-insurance is determined by Prescription Drug Products on the Prescription Drug List placed on Tier 1, Tier 2, Tier 3, Tier 4, Tier 5, Tier 6 .
- Prescription Drug Products supply limit:
  - Retail Network Pharmacy – 30 or 90 days
  - Mail Order Network Pharmacy – 90 days
  - Opioid Prescription Drug Products at a Network Pharmacy – 30 days
- Ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate, not 30-day supply with three refills.
- You will be charged a Co-payment and/or Co-insurance based on the day supply dispensed or days the drug will be delivered for any Prescription Orders or Refills at any Network Pharmacy.

AMOUNTS SHOWN ARE YOUR COST RESPONSIBILITY AFTER ANY APPLICABLE DEDUCTIBLE HAS BEEN MET			
The amounts you are required to pay as shown below are based on the Prescription Drug Charge.			
	Retail Network Pharmacy		Mail Order Network Pharmacy
	30-Day Supply	90-Day Supply	90-Day Supply
Tier 1	No Co-payment Not subject to payment of the Annual Drug Deductible	No Co-payment Not subject to payment of the Annual Drug Deductible	No Co-payment Not subject to payment of the Annual Drug Deductible
Tier 2	$25 per Prescription Order or Refill. Not subject to payment of the Annual Drug Deductible.	$62.50 per Prescription Order or Refill. Not subject to payment of the Annual Drug Deductible.	$62.50 per Prescription Order or Refill. Not subject to payment of the Annual Drug Deductible.
Tier 3	$25 per Prescription Order or Refill. Not subject to payment of the Annual Drug Deductible.	$62.50 per Prescription Order or Refill. Not subject to payment of the Annual Drug Deductible.	$62.50 per Prescription Order or Refill. Not subject to payment of the Annual Drug Deductible.
Tier 4	$75 per Prescription Order or Refill. Subject to payment of the Annual Drug Deductible.	$187.50 per Prescription Order or Refill. Subject to payment of the Annual Drug Deductible.	$187.50 per Prescription Order or Refill. Subject to payment of the Annual Drug Deductible.
Tier 5	$80 per Prescription Order or Refill. Subject to payment of the Annual Drug Deductible.	$200 per Prescription Order or Refill. Subject to payment of the Annual Drug Deductible.	$200 per Prescription Order or Refill. Subject to payment of the Annual Drug Deductible.
Tier 6	$100 per Prescription Order or Refill. However, you will not pay more than $150 per Prescription Order or Refill. Subject to payment of the Annual Drug Deductible.	$250 per Prescription Order or Refill. However, you will not pay more than $150 per Prescription Order or Refill. Subject to payment of the Annual Drug Deductible.	$250 per Prescription Order or Refill. However, you will not pay more than $150 per Prescription Order or Refill. Subject to payment of the Annual Drug Deductible.

Pediatric Dental Care Services Schedule of Benefits

How do you Access Pediatric Dental Care Services?

Network Benefits

Benefits - Benefits apply when you choose to obtain Covered Dental Care Services from a Network Dental Provider. Network Benefits are determined based on the contracted fee for each Covered Dental Service. In no event, will you be required to pay a Network Dental Provider an amount for a Covered Dental Service that is greater than the contracted fee.

In order for Covered Dental Care Services to be paid, you must obtain all Covered Dental Care Services directly from or through a Network Dental Provider.

You must always check the participation status of a provider prior to seeking services. From time to time, the participation status of a provider may change. You can check the participation status by contacting us and/or the provider. We can provide help in referring you to a Network Dental Provider.

We will make available to you a *Directory of Network Dental Providers*. You can also call us at the number stated on your identification (ID) card to determine which providers participate in the Network.

Benefits are not available for Dental Care Services that are not provided by a Network Dental Provider.

Referral to Out-of-Network Specialist

You may request a referral to an out-of-Network Dental Provider who is a non-Physician Specialist if a Covered Person is diagnosed with a condition or disease that requires specialized Dental Services, and:

- There is no Network Dental Provider with the professional training and expertise to treat or provide Dental Services for the condition or disease; or
- We cannot provide reasonable access to a Network Dental Provider with the professional training and expertise to treat or provide Dental Services for the condition or disease without unreasonable delay or travel.

The Covered Person or Dental Provider requesting the referral must contact us to obtain our approval of the referral.

The term "non-Physician Specialist" means a health care provider who:

- Is not a Physician;
- Is licensed or certified under the Maryland Health Occupations Article; and
- Is certified or trained to treat or provide Dental Services for a specified condition or disease in a manner that is within the scope of the license or certification of the health care provider.

Payment Information

Benefits:

Benefits for Allowed Dental Amounts are determined as a percentage of the negotiated contract fee between us and the provider rather than a percentage of the provider's billed charge. Our negotiated rate with the provider is ordinarily lower than the provider's billed charge.

A Network provider cannot charge you or us for any service or supply that is not Necessary as determined by us. If you agree to receive a service or supply that is not Necessary the Network provider may charge you. However, these charges will not be considered Covered Dental Care Services and Benefits will not be payable.

Annual Deductible

Benefits for Pediatric Dental Care Services provided under this section are not subject to the Annual Deductible stated in the *Schedule of Benefits*.

Out-of-Pocket Limit - any amount you pay in Coinsurance for Pediatric Dental Care Services under this section applies to the Out-of-Pocket Limit stated in the *Schedule of Benefits*.

Schedule of Benefits Information Table

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
Diagnostic Services - (Not subject to payment of the Annual Deductible.)	
Evaluations (Checkup Exams) Limited to 2 per 12 months per patient per Network Dental Provider or location. Periodic oral evaluation Oral evaluation for patients under 3 years of age in counseling with primary caregiver. Teledentistry - synchronous - real time encounter. Teledentistry - asynchronous - information stored and forwarded to dentist for subsequent review. Comprehensive oral evaluation – new or established patient. Comprehensive periodontal evaluation. Detailed and extensive oral evaluation - problem focused, by report. *The following service is not subject to a frequency limit.* Limited oral evaluation - problem focused.	None
Intraoral Radiographs (X-ray) Intraoral - complete series of radiographic images - one per 36 months, per provider or location. Limited to 2 series per 12 months, per Network Dental Provider or location. Intraoral - comprehensive series of radiographic images - image capture only. Intraoral - occlusal radiographic image - image capture only. Intraoral - occlusal film.	None
The following services are not subject to a frequency limit. Intraoral - periapical first radiographic image. Intraoral - periapical - each additional radiographic image. Intraoral - periapical radiographic image - image capture only. Extraoral -2D projection radiographic images created using a stationary radiation source and detector. Bitewing - single radiographic image. Intraoral - bitewing radiographic image - image capture only.	None

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
Any combination of the following services is limited to 2 series of films per 12 months. Bitewings - two radiographic image, per Network Dental Provider. Bitewings - three radiographic image, per Network Dental Provider. Bitewings - four radiographic image, per Network Dental Provider.	None
The following services are not subject to a frequency limit. Sialography. Temporomandibular joint arthogram, including injection. Other temporomandibular joint films, by report	None
Limited to 1 per 36 months per provider or location. Panoramic radiograph image. Cephalometric radiographic image. Panoramic radiographic image - image capture only. 2-D Cephalometric radiographic image – image capture only 2-D Cephalometric radiographic image - acquisition, measurement and analysis. 3-D Photographic image - image capture only.	None
The following services are limited to two images per calendar year. Extra-oral posterior dental radiographic image - image capture only.	None
The following services are not subject to a frequency limit. Oral/Facial photographic images. Interpretation of diagnostic image. Diagnostic casts. 2-D Oral/facial photographic image obtained intra-orally or extra-orally - image capture only.	None
The following service is limited to one every 12 months per patient. Covered only when clinically Necessary. Adjunctive pre-diagnostic test that: aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures.	None
The following service is not subject to a frequency limit. Pulp vitality tests, limited to one per visit.	None

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
Preventive Services – (Not subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) *The following services are limited to two times every 12 months.* Prophylaxis – adult. Prophylaxis – child.	None
Fluoride Treatments Topical fluoride varnish (minimum of 30 days required between applications), limited to the following: • For Covered Persons age 0 to 2 years old, 8 per 12 months, per Network Dental Provider or location. • For Covered Persons age 3 until the end of the calendar year in which the Covered Person turns age 19, 4 per 12 months, per Network Dental Provider or location. Fluoride, limited to two every 12 months.	None
The following service is limited to one every 12 months: Oral hygiene instructions.	None
Sealants (Protective Coating) *The following services are* limited to once per lifetime per patient per tooth. Covered only for the occlusal surfaces of the posterior permanent teeth without restorations or decay. Sealant - per tooth - unrestored permanent molar. Preventive resin restorations in moderate to high caries risk patient - permanent tooth.	None
Space Maintainers (Spacers) *The following services are limited to one per 24 months.* Space maintainer - fixed, unilateral - per quadrant. Space maintainer - fixed - bilateral maxillary. Space maintainer - fixed - bilateral mandibular. Space maintainer - removable, unilateral - per quadrant. Space maintainer - removable - bilateral maxillary. Space maintainer - removable - bilateral mandibular. Re-cement or re-bond bilateral space maintainer - maxillary. Re-cement or re-bond bilateral space maintainer - mandibular.	None

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
Re-cement or re-bond unilateral space maintainer - per quadrant, not covered within 6 months of initial placement *The following services are not subject to a frequency limit:* Removal of fixed unilateral space maintainer - per quadrant. Removal of fixed bilateral space maintainer - maxillary. Removal of fixed bilateral space maintainer - mandibular. Distal shoe space maintainer - fixed - unilateral - per quadrant.	
Minor Restorative Services - (Not subject to payment of the Annual Deductible.)	
Amalgam Restorations (Silver Fillings) *The following services are not subject to a frequency limit. Multiple restorations on one surface will be treated as a single filling.* Amalgams - one surface, primary or permanent. Amalgams - two surfaces, primary or permanent. Amalgams - three surfaces, primary or permanent. Amalgams - four or more surfaces, primary or permanent.	20%
Composite Resin Restorations (Tooth Colored Fillings) *The following services are not subject to a frequency limit. Multiple restorations on one surface will be treated as a single filling.* Resin-based composite - one surface, anterior. Resin-based composite - two surfaces, anterior. Resin-based composite - three surfaces, anterior. Resin-based composite - four or more surfaces or involving incised angle, anterior. Resin-based composite crown, anterior. *The following services are limited to one per tooth every 12 months. Multiple restorations on one surface will be treated as a single filling.* Resin-based composite - one surface, posterior. Resin-based composite - two surfaces, posterior. Resin-based composite - three surfaces, posterior. Resin-based composite - four or more surfaces, posterior.	20%
Crowns/Inlays/Onlays - (Not subject to payment of the Annual Deductible.)	

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
The following services are subject to a limit of one time every 60 months. Onlay - metallic - two surfaces. Onlay - metallic - three surfaces. Onlay - metallic - four surfaces. Crown - resin with predominantly base metal. Crown - porcelain/ceramic substrate. Crown - porcelain fused to high noble metal. Crown - porcelain fused to predominately base metal. Crown - porcelain fused to noble metal. Crown - porcelain fused to titanium and titanium alloys. Crown - 3/4 cast high noble metal. Crown - 3/4 cast predominately base metal. Crown - 3/4 cast noble metal. Crown - 3/4 porcelain/ceramic. Crown - full cast high noble metal. Crown - full cast predominately base metal. Crown - full cast noble metal. Crown - titanium. *The following services are not subject to a frequency limit.* Inlay - metallic - one surface. Inlay - metallic - two surfaces. Inlay - metallic - three surfaces. Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration. Re-cement or re-bond crown, not allowed within 6 months of initial placement	50%
The following services are limited to one time per tooth every 36 months. Prefabricated porcelain/ceramic crown - permanent tooth. Prefabricated porcelain/ceramic crown - primary tooth. Prefabricated stainless-steel crown - permanent tooth. Prefabricated stainless-steel crown - primary tooth. Prefabricated resin crown. Prefabricated stainless-steel crown with resin window. Prefabricated esthetic coated stainless steel crown - primary tooth.	50%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
The following service is not subject to a frequency limit. Protective restoration.	50%
The following service is limited to one time per tooth every 60 months. *Prefabricated porcelain crown - primary.* Core buildup, including any pins. Cast post and core in addition to crown.	50%
The following service is limited to one per 60 months per patient per tooth. Prefabricated post and core in addition to crown.	50%
The following services are not subject to a frequency limit. Pin retention - per tooth, in addition to restoration. Post removal (not in conjunction with endodontic therapy). Crown repair necessitated by restorative material failure. Inlay repair. Onlay repair. Veneer repair. *The following service is limited to one time per tooth every 36 months.* Resin infiltration/smooth surface.	50%
The following services are limited to one per tooth every 60 months. Labial veneer (laminate) - chair. Labial veneer (resin laminate) - laboratory. Labial veneer (porcelain laminate) - laboratory.	50%
Endodontics – (Not subject to payment of the Annual Deductible.)	
The following service is not subject to a frequency limit. Pulp cap - direct (excluding final restoration). Pulp cap - indirect (excluding final restoration). Therapeutic pulpotomy (excluding final restoration). Pulpal debridement, primary and permanent teeth.	20%
The following service is not subject to a frequency limit. Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development.	20%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
The following services are limited to one per lifetime per patient per tooth. Pulpal therapy (resorbable filling) - anterior primary tooth (excluding final restoration). Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).	20%
The following services are limited to one per lifetime per patient per tooth. Endodontic therapy, Anterior tooth (excluding final restoration). Endodontic therapy, Bicuspid tooth (excluding final restoration). Endodontic therapy, Molar tooth (excluding final restoration). Retreatment of previous root canal therapy - anterior. Retreatment of previous root canal therapy - molar. *The following service is not subject to a frequency limitation.* Retreatment of previous root canal therapy – bicuspid.	20%
The following services are limited to one per lifetime per patient per tooth. Apexification/recalcification – initial visit (apical closure / calcific repair of perforations, root resorption, etc.). Apexification/recalcification - interim medication replacement. Apexification/recalcification - final visit (includes completed root canal therapy-apical closure/calcific repair of perforations, root resorption, etc.).	20%
The following service is not subject to a frequency limit. Pulpal regeneration - initial visit. Pulpal regeneration - interim medication replacement. Pulpal regeneration - completion of treatment.	20%
The following services are limited to one per lifetime per patient per tooth. Apicoectomy - anterior. Apicoectomy – bicuspid (first root). Apicoectomy – molar (first root). Apicoectomy - each additional root. Retrograde filling - per root. Root amputation - per root. Intentional reimplantation.	20%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
Hemisection (including any root removal), not including root canal therapy. *The following services are not subject to a frequency limit.* Surgical repair of root resorption - anterior. Surgical repair of root resorption - premolar. Surgical repair of root resorption - molar. Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior. Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar. Surgical exposure of root surface without apicoectomy or repair of root resorption - molar.	
Periodontics - (Not subject to payment of the Annual Deductible.)	
The following services are limited to one per quadrant every 24 months and 2 quadrants every 12 months. Gingivectomy or gingivoplasty - four or more teeth. Gingivectomy or gingivoplasty - one to three teeth. Gingivectomy or gingivoplasty - with restorative procedures, per tooth.	20%
The following services are limited to any one per lifetime per patient. Anatomical crown exposure, 4+ teeth per quadrant. Anatomical crown exposure, 1 to 3 teeth per quadrant.	20%
The following services are limited to one per quadrant every 24 months per patient. A minimum of four teeth in the affected quadrant. Gingival flap procedure, including root planing , four or more contiguous teeth or tooth bound spaces per quadrant. Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant.	20%
The following service is limited to one per 24 months per patient per tooth. Clinical crown lengthening - hard tissue.	20%
The following services are limited to one per quadrant every 24 months. A minimum of four teeth in the affected quadrant. Osseous surgery (including elevation of a full thickness flap and closure)- four or more contiguous teeth or tooth bounded spaces per quadrant.	20%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
Osseous surgery (including elevation of a full thickness flap and closure)one to three contiguous teeth or bounded teeth spaces per quadrant. Bone replacement graft - first site in quadrant.	
The following services are not subject to a frequency limit. Pedicle soft tissue graft procedure. Free soft tissue graft procedure.	20%
The following services are not subject to a frequency limit. Subepithelial connective tissue graft procedures, per tooth. Soft tissue allograft. Free soft tissue graft - first tooth. Free soft tissue graft - additional teeth.	20%
The following service is not subject to a frequency limit. Covered only when clinically Necessary. Unscheduled dressing change (by someone other than the original treating dentist).	20%
The following services are not subject to a frequency limit. Splint - intra-coronal; natural teeth or prosthetic crown. Splint - extra-coronal; natural teeth or prosthetic crown.	20%
The following services are limited to one time per quadrant every 24 months. A minimum of four teeth in the affected quadrant. Limited to permanent dentition. Periodontal scaling and root planing - four or more teeth per quadrant. Periodontal scaling and root planing - one to three teeth per quadrant. Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation.	20%
The following service is limited to one time every 24 months. Full mouth debridement to enable comprehensive evaluation and diagnosis.	20%
The following service is limited to two per 12 months per patient. Periodontal maintenance.	20%
Removable Dentures - (Not subject to payment of the Annual Deductible.)	

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
The following services are limited to a frequency of one every 60 months. Complete denture - maxillary. Complete denture - mandibular. Immediate denture - maxillary. Immediate denture - mandibular. Mandibular partial denture - resin base (including conventional clasps, rests, and teeth). Maxillary partial denture - resin base (including conventional clasps, rests, and teeth). Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth). Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth). Maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth). Mandibular partial denture - flexible base (including any clasps, rests and teeth). Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth). Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth). Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth). Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth). Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary. Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular. Removable unilateral partial denture - one piece flexible base (including retentive/clasping materials, rests, and teeth) - per quadrant. Removable unilateral partial denture - one piece resin (including retentive/clasping materials, rests, and teeth) - per quadrant.	50%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
The following services are limited to adjusting performed more than 6 months after the initial placement and are not subject to a frequency limit. Adjust complete denture - maxillary. Adjust complete denture - mandibular. Adjust partial denture - maxillary. Adjust partial denture - mandibular. *The following services are not subject to a frequency limit.* Repair broken complete denture base. Repair broken complete denture base - mandibular. Repair broken complete denture base - maxillary. Replace missing or broken teeth - complete denture (each tooth). Repair resin denture base. Repair resin partial denture base - mandibular. Repair resin partial denture base - maxillary. Repair cast framework. Repair cast partial framework - mandibular. Repair cast partial framework - maxillary. Repair or replace broken retentive/clasping materials - per tooth. Replace broken teeth - per tooth. Add tooth to existing partial denture. Add clasp to existing partial denture. Re-cement or re-bond fixed partial denture.	50%
The following services are limited to rebasing performed more than 6 months after the initial insertion with a frequency limitation of one time per 24 months per patient. Rebase complete maxillary denture. Rebase complete mandibular denture. Rebase maxillary partial denture. Rebase mandibular partial denture. Reline complete maxillary denture (laboratory). Reline complete mandibular denture (laboratory). Reline maxillary partial denture (laboratory). Reline mandibular partial denture (laboratory). Add metal substructure to acrylic full denture (per arch).	50%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
The following services are not subject to a frequency limit. Prior to new denture impression only. Tissue conditioning (maxillary). Tissue conditioning (mandibular).	50%
The following services are limited to one every 60 months per patient. Overdenture - complete maxillary. Overdenture - partial maxillary. Overdenture - complete mandibular. Overdenture - partial mandibular.	50%
The following services are limited to one per six months per arch. Adjust maxillofacial prosthetic appliance, by report. Maintenance and cleaning of a maxillofacial prosthesis (extra or intraoral) other than required adjustments.	50%
Oral Surgery - (Not subject to payment of the Annual Deductible.)	
The following service is not subject to a frequency limit. Extraction coronal remnants, deciduous teeth. Extraction, erupted tooth or exposed root (elevation and/or forceps removal).	20%
The following services are not subject to a frequency limit. Removal of asymptomatic tooth not covered. Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth. Removal of impacted tooth - soft tissue. Removal of impacted tooth - partially bony. Removal of impacted tooth - completely bony. Removal of impacted tooth - completely bony with unusual surgical complications. Surgical removal of residual tooth roots (cutting procedure). *The following service is limited to one time per tooth per lifetime* Coronectomy - intentional partial tooth removal , impacted teeth only, performed when a neurovascular complication is likely if the entire impacted tooth is removed.	20%
The following service is not subject to a frequency limit. Oroantral fistula closure.	20%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth. Includes splinting and/or stabilization.	
The following service is limited to one time per tooth per lifetime. Covered only when clinically Necessary. Tooth transplantation (includes reimplantation from one site to another).	20%
The following services are not subject to a frequency limit. Surgical access of an unerupted tooth. Incisional biopsy of oral tissue - hard (bone, tooth). Incisional biopsy of oral tissue - soft.	20%
The following service is limited to once per tooth per lifetime. Surgical repositioning of teeth.	20%
The following services are limited to one per lifetime per patient per quadrant. Alveoloplasty in conjunction with extractions-four or more teeth or tooth spaces, per quadrant. Alveoloplasty in conjunction with extraction - one to three teeth or tooth spaces - per quadrant. Alveoloplasty not in conjunction with extractions- four or more teeth or tooth spaces, per quadrant Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces - per quadrant.	20%
The following services are not subject to a frequency limit. Removal of lateral exostosis (maxilla or mandible). Vestibuloplasty-ridge extension (secondary epithelialization). Vestibuloplasty-ridge extension. Radical excision-lesion diameter up to 1.25 cm. Excision of malignant tumor - lesion diameter up to 1.25 cm. Removal of odontogenic cyst or tumor-lesion diameter up to 1.25 cm. Removal of odontogenic cyst or tumor-lesion greater than 1.25 cm. Removal of nonodontogenic cyst or tumor-lesion diameter up to 1.25 cm. Removal of nonodontogenic cyst or tumor-lesion greater than 1.25 cm.	20%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
Removal of torus palatinus. Removal of mandibularis.	
The following services are not subject to a frequency limit. Incision and drainage of abscess - intraoral soft tissue. Incision and drainage of abscess - extraoral soft tissue. Partial ostectomy/sequestrectomy for removal of non-vital bone. Excision of hyperplastic tissue. Suture of recent small wounds up to 5 cm. Collect - apply autologous product. Bone replacement graft for ridge preservation - per site. *The following services are limited to one per lifetime per patient - per tooth.* Buccal/labial frenectomy (frenulectomy). Lingual frenectomy (frenulectomy). Excision of pericoronal gingiva.	20%
Adjunctive Services - (Not subject to payment of the Annual Deductible.)	
The following service is not subject to a frequency limit; however, it is covered as a separate Benefit only if no other services (other than the exam and radiographs) were done on the same tooth during the visit. Palliative (Emergency) treatment of dental pain.	20%
Covered only when clinically Necessary. Deep sedation/general anesthesia first 30 minutes. Dental sedation/general anesthesia each additional 15 minutes. Deep sedation/general anesthesia - first 15 minutes. Inhalation of nitrous oxide/analgesia. Intravenous moderate (conscious) sedation/anesthesia - first 15 minutes. Intravenous conscious sedation/analgesia - first 30 minutes. Intravenous conscious sedation/analgesia - each additional 15 minutes. Non-intravenous moderate (conscious) sedation. Therapeutic drug injection, by report.	20%
Covered only when clinically Necessary.	20%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
Consultation (diagnostic service provided by a dentist or Physician other than the practitioner providing treatment).	
The following services are not subject to a frequency limit. House/extended care facility call. Hospital or ambulatory surgical center call. *The following service is limited to one per visit.* Application of desensitizing medicament. *The following service is limited to one per 12 months per patient.* Fabrication of athletic mouthguard.	20%
The following are limited to one guard every 24 months. Occlusal guard - hard appliance, full arch. Occlusal guard - soft appliance, full arch. Occlusal guard - hard appliance, partial arch.	20%
Implant Procedures - (Not subject to payment of the Annual Deductible.)	
The following are provided when no other restorative procedure is provided on the same date of service, limited to a frequency of one per 12 months. Occlusal adjustment - complete. Unspecified adjunctive procedure by report. *The following is provided when no other restorative procedure is provided on the same date of service, limited to a frequency of two per 12 months.* Occlusal adjustment - limited.	20%
Medically Necessary Orthodontics - (Not subject to payment of the Annual Deductible.)	
Benefits for comprehensive orthodontic treatment are only available if the Covered Person: • Has fully erupted permanent teeth with at least 1/2 to 3/4 of the clinical crown being exposed (unless the tooth is impacted or congenitally missing); and • Has a severe, dysfunctional, handicapping malocclusion that meets the minimum score of 15 on the Handicapping Labio-Lingual Deviations Index (HLD) approve for use by the State of Maryland. Points are not awarded for aesthetics, therefore additional points for handicapping aesthetics will not be considered as part of the determination. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed. Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be Medically Necessary.	

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
The following services are not subject to a frequency limitation as long as benefits have been prior authorized. Limited orthodontic treatment of the primary dentition. Limited orthodontic treatment of the transitional dentition. Limited orthodontic treatment of the adolescent dentition. Interceptive orthodontic treatment of the primary dentition. Interceptive orthodontic treatment of the transitional dentition. Removable appliance therapy. Fixed appliance therapy. *The following services are limited to one per lifetime per patient.* Comprehensive orthodontic treatment of the transitional dentition. Comprehensive orthodontic treatment of the adolescent dentition. Comprehensive orthodontic treatment of the adult dentition. Orthodontic retention (removal of appliance). Only payable when the original provider differs from the provider performing the continuation of care for debanding and retention. Removal of fixed orthodontic appliances for reasons other than completion of treatment. *The following service is limited to one per 12 months per patient.* Pre-orthodontic treatment visit. *The following service is limited to 24 per lifetime per patient.* Periodic orthodontic treatment visit. For comprehensive orthodontic treatment using self-ligating appliances, a maximum of 24 of (D8670) per 1 lifetime per patient. *The following services are limited to one per patient within 24 months of the date of debanding.* Repair of orthodontic appliance - maxillary. Repair of orthodontic appliance - mandibular. *The following services are limited to one per arch per lifetime. Allowed within 24 months of debanding.*	50%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits** **The Amount You Pay Which May Include a Co-insurance or Co-Payment.**
Replacement of lost or broken retainer - maxillary. Replacement of lost or broken retainer - mandibular. *The following services are not subject to a frequency limit.* Re-cement or re-bond fixed retainer – maxillary. Re-cement or re-bond fixed retainer – mandibular. Repair of fixed retainer, includes reattachment – maxillary. Repair of fixed retainer, includes reattachment – mandibular.	

Pediatric Vision Care Services Schedule of Benefits

How do you Access Pediatric Vision Care Services?

Network Benefits

Benefits - Benefits are available for pediatric Vision Care Services from a UnitedHealthcare Vision Network Vision Care Provider. To find a UnitedHealthcare Vision Network Vision Care Provider, you may call the provider locator service at 1-800-691-0021. You may also access a listing of UnitedHealthcare Vision Network Vision Care Providers on the Internet at www.myuhc.com/exchange.

Benefits are not available for Vision Care Services that are not provided by a UnitedHealthcare Vision Network Vision Care Provider.

Payment Information

Benefits for Vision Care Services are determined based on the negotiated contract fee between us and the Vision Care Provider. Our negotiated rate with the Vision Care Provider is ordinarily lower than the Vision Care Provider's billed charge.

Annual Deductible

Unless otherwise stated, Benefits for pediatric Vision Care Services provided under this section are subject to any Annual Deductible stated in the *Schedule of Benefits.*

Out-of-Pocket Limit - any amount you pay in Co-insurance for Vision Care Services under this section applies to the Out-of-Pocket Limit stated in the *Schedule of Benefits*.

Schedule of Benefits Information Table

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

Vision Care Service	What Is the Frequency of Service?	Benefit - The Amount You Pay Based on the Contracted Rate
Routine Vision Exam, including dilation, if professionally indicated	Once every 12 months.	None per exam. Not subject to payment of the Annual Deductible.
Eyeglass Lenses	Once every 12 months.	
• Single Vision		None per pair of eyeglass lenses. Subject to payment of the Annual Deductible.
• Bifocal		None per pair of eyeglass lenses. Subject to payment of the Annual Deductible.
• Trifocal		None per pair of eyeglass lenses. Subject to payment of the Annual Deductible.
• Lenticular		None per pair of eyeglass lenses. Subject to payment of the Annual Deductible.
Lens Extras		
• Polycarbonate lenses	Once every 12 months.	None Not subject to payment of the Annual Deductible.

Vision Care Service	What Is the Frequency of Service?	Benefit - The Amount You Pay Based on the Contracted Rate
• Standard scratch-resistant coating	Once every 12 months.	None Not subject to payment of the Annual Deductible.
Eyeglass Frames	Once every 12 months.	
• Eyeglass frames with a retail cost up to $130.		None per eyeglass frame. Not subject to payment of the Annual Deductible.
• Eyeglass frames with a retail cost of $130 - 160.		None per eyeglass frame. Not subject to payment of the Annual Deductible.
• Eyeglass frames with a retail cost of $160 - 200.		None per eyeglass frame. Not subject to payment of the Annual Deductible.
• Eyeglass frames with a retail cost of $200 - 250.		None per eyeglass frame. Not subject to payment of the Annual Deductible.
• Eyeglass frames with a retail cost greater than $250.		None Not subject to payment of the Annual Deductible.
Contact Lenses and Fitting & Evaluation		
• Contact Lens Fitting & Evaluation	Once every 12 months.	None Not subject to payment of the Annual Deductible.
• Covered Contact Lens Formulary	Limited to a 12 month supply.	None per supply of contact lenses. Not subject to payment of the Annual Deductible.
Necessary Contact Lenses	Limited to a 12 month supply.	None per supply of contact lenses. Subject to payment of the Annual Deductible.
Low Vision Care Services: Note that Benefits for these services will be paid as reimbursements. When obtaining these Vision Care Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Limited to one comprehensive low vision evaluation every 5 years and 4 follow-up visits in any 5-year period.	
• Low vision testing		None of billed charges. Subject to payment of the Annual Deductible.

Vision Care Service	What Is the Frequency of Service?	Benefit - The Amount You Pay Based on the Contracted Rate
• Low vision therapy		None of billed charges. Subject to payment of the Annual Deductible.
• Prescribed Optical Devices		None of billed charges. Subject to payment of the Annual Deductible.

Policy Table of Contents

Section 1: Covered Health Care Services

When Are Benefits Available for Covered Health Care Services?

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

- The health care service, including supplies or Pharmaceutical Products, is only a Covered Health Care Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Care Service in *Section 8: Defined Terms*.)
- You receive Covered Health Care Services while this Policy is in effect.
- You receive Covered Health Care Services prior to the date that any of the individual termination conditions listed in *Section 4: When Coverage Ends* occurs.
- The person who receives Covered Health Care Services is a Covered Person and meets all eligibility requirements.

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 Care Service under this Policy.

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

- The amount you must pay for these Covered Health Care Services (including any Annual Deductible, Co-payment and/or Co-insurance).
- Any limit that applies to these Covered Health Care Services (including visit, day and dollar limits on services).
- Any limit that applies to the portion of the Allowed Amount or the Recognized Amount when applicable, you are required to pay in a year (Out-of-Pocket Limit).
- Any responsibility you have for obtaining prior authorization or notifying us.

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

1. Acupuncture

Benefits will be provided for Medically Necessary acupuncture services when performed by a provider licensed to perform such services.

2. Ambulance Services

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

Non-Emergency ambulance transportation by a licensed ambulance service (either ground or Air Ambulance, as we determine appropriate) between facilities only when the transport meets one of the following:

- From an out-of-Network Hospital to the closest Network Hospital when Covered Health Care Services are required.
- To the closest Network Hospital that provides the required Covered Health Care Services that were not available at the original Hospital.
- From a short-term acute care facility to the closest Network long-term acute care facility (LTAC), Network Inpatient Rehabilitation Facility, or other Network sub-acute facility where the required Covered Health Care Services can be delivered.

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

  - "Long-term acute care facility (LTAC)" means a facility or Hospital that provides care to people with complex medical needs requiring long-term Hospital stay in an acute or critical setting.

- "Short-term acute care facility" means a facility or Hospital that provides care to people with medical needs requiring short-term Hospital stay in an acute or critical setting such as for recovery following a surgery, care following sudden Sickness, Injury, or flare-up of a chronic Sickness.
- "Sub-acute facility" means a facility that provides intermediate care on short-term or long-term basis.

3. Clinical Trials

Routine patient care costs incurred while taking part 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 which is likely to cause death unless the course of the disease or condition is interrupted.
- Cardiovascular disease (cardiac/stroke) which is not life threatening, when we determine the clinical trial meets the qualifying clinical trial criteria stated below.
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, when we determine the clinical trial meets the qualifying clinical trial criteria stated below.
- Other diseases or disorders which are not life threatening, when we determine the 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 taking part in a qualifying clinical trial.

Benefits are available only when you are clinically eligible, as determined by the researcher, to take part in the qualifying clinical trial.

Routine patient care costs for qualifying clinical trials include:

- Covered Health Care Services for which Benefits are typically provided absent a clinical trial.
- Covered Health Care Services required solely for the following:
  - The provision of the Experimental or Investigational Service(s) or item.
  - The clinically appropriate monitoring of the effects of the service or item, or
  - The prevention of complications.
- Covered Health Care Services needed for reasonable and necessary care arising from the receipt of an Experimental or Investigational Service(s) or item.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service(s) or item. The only exceptions to this are:
  - Certain *Category B* devices.
  - Certain promising interventions for patients with Terminal Illnesses.
  - Other items and services that meet specified criteria in accordance with our medical and drug policies.
- Items and services provided solely to meet data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that clearly does not meet widely accepted and established standards of care for a particular diagnosis.
- Items and services provided by the research sponsors free of charge for any person taking part 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. It takes place in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition. It meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease, musculoskeletal disorders of the spine, hip and knees and other diseases or disorders which are not life-threatening, a qualifying clinical trial is a Phase I, Phase II, or Phase III clinical trial. It takes place in relation to the detection or treatment of such non-life-threatening disease or disorder. It 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.
- The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* if the study or investigation has been reviewed and approved through a system of peer review. The peer review system is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
  - Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*.
  - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

- The study or investigation takes place 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. It must have been approved by all relevant institutional review boards (*IRBs*) before you are enrolled in the trial. We may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Care Service and is not otherwise excluded under this Policy.

4. Dental Anesthesia

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

(A) Is a child seven years of age or younger or is developmentally disabled;
- Is an individual for whom a successful result cannot be expected from dental care provided under a local anesthesia because of a physical, intellectual, or other medically compromising condition; and
- Is an individual for whom a superior result can be expected from dental care provided under general anesthesia; or

(B) Is an extremely uncooperative, fearful, or uncommunicative child who is 17 years of age or younger with dental needs of such magnitude that treatment should not be delayed or deferred; and
- Is an individual for whom lack of treatment can be expected to result in oral pain, infection, loss of teeth, or other increased oral or dental morbidity.

Such services must be provided under the direction of a Physician or dentist. Benefits are not provided for expenses for the diagnosis or treatment of dental disease.

5. Dental Services - Accident Only

Dental services when all of the following are true:

- Treatment is needed because of accidental damage.
- You receive dental services from a Doctor of Dental Surgery or Doctor of Medical Dentistry.
- The dental damage is severe enough that first contact with a Physician or dentist happened within 72 hours of the accident. (You may request this time period be longer if 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 happens as a result of normal activities of daily living or extraordinary use of the teeth is not considered an accidental Injury. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

Dental services to repair damage caused by accidental Injury must follow these time-frames:

- Treatment is started within six months of the accident, or if not a Covered Person at the time of the accident, within the first six months of coverage under the Policy, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care). If, due to the nature of the injury, treatment could not begin within six months of the accident, treatment is started within six months of the earliest date that it would be medically appropriate to begin such treatment.
- Treatment must be 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 Policy.

Benefits for treatment of accidental Injury are limited to the following:

- Emergency exam.
- Diagnostic X-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.
- Prefabricated post and core.
- Simple minimal restorative procedures (fillings).
- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to Injury with implant, dentures or bridges.

6. Diabetes Services

Diabetes Self-Management and Training and Education Services

"Diabetes self-management training and educational services" means instruction in an inpatient or outpatient setting which enables diabetic patients to understand the diabetic management process and daily management of diabetic therapy as a method of avoiding frequent hospitalizations and complications, when the instruction is provided in accordance with a program in compliance with the National Standards of Diabetes Self-Management Education Program as developed by the American Diabetes Association. Diabetes self-management training and educational services includes coverage for medical nutrition therapy when prescribed by a health care professional and when provided by a certified, registered or licensed health care professional. Diabetes self-management training and educational services does not include programs with the primary purpose of weight reduction. Benefits also include medical eye exams (dilated retinal exams) and preventive foot care, and diabetic specific foot orthotics, orthopedic shoes, inserts, modifications, and footwear when Medically Necessary for the treatment of complications related to diabetes.

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services when services are ordered by a Physician and provided by appropriately licensed, certified or registered health care professionals. The provider certifies the services are necessary for the treatment of:

- Insulin using diabetes;
- Non-insulin using diabetes;
- Elevated or impaired blood glucose levels induced by Pregnancy; or
- Elevated or impaired blood glucose levels induced by prediabetes in accordance with the American Diabetes Association’s standards.

Diabetes self-management training includes training provided to you after the initial diagnosis of diabetes and or Pregnancy induced elevated blood glucose levels in the care and management of those conditions, including nutritional counseling and proper use of the diabetic self-management items listed below. Benefits are also provided for additional training upon diagnosis of a significant change in medical condition that requires a change in the self-

management regime, and periodic continuing education training as warranted by the development of new techniques and treatment for diabetes.

Diabetic Self-Management Supplies

Benefits for blood glucose control and testing including insulin syringes with needles, blood glucose and urine test strips, lancets and lancet devices, ketone test strips and glucose tablets, single measurement glucose monitors, including those for the legally blind, and certain insulin pumps, are described under the *Outpatient Prescription Drugs* section. Continuous glucose monitors are excluded as described under the *Outpatient Prescription Drugs* section. Continuous glucose monitors and certain insulin pumps are subject to all the conditions of coverage stated under Durable Medical Equipment (DME).

7. Durable Medical Equipment (DME)

Benefits are provided for DME. If more than one item can meet your functional needs, Benefits are available only for the item that meets the minimum specifications for your needs. If you purchase an item that exceeds these minimum specifications, we will pay only the amount that we would have paid for the item that meets the minimum specifications, and you will be responsible for paying any difference in cost.

DME includes, but isn't limited to:

- Canes.
- Cochlear implants and batteries for cochlear implants.
- Commode chairs.
- Continuous glucose monitors.
- Continuous passive motion devices.
- Continuous Positive Airway Pressure (CPAP) devices.
- Crutches.
- Hospital beds.
- Insulin pumps.
- Infusion pumps.
- Nebulizers and peak flow meters.
- Oxygen equipment.
- Patient lifts.
- Pressure-reducing support surfaces.
- Suction pumps.
- Traction equipment.
- Walkers.
- Wheelchairs.

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

Benefits are available for fitting, repairs and replacement, except when due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

These Benefits apply to external DME. Unless otherwise excluded, items that are fully implanted into the body are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Service categories in this Policy.

8. Emergency Health Care Services - Outpatient

Services that are required To Stabilize or begin treatment in an Emergency. Emergency Health Care Services must be received on an outpatient basis at a Hospital or Alternate Facility. Refer to the definition of Emergency Health Care Services in *Section 8: Defined Terms* for a complete definition of Emergency Health Care Services. Services will be provided:

- Without the need for any prior authorization determination, even if the Emergency Health Care Services are provided on an out-of-network basis;
- Without regard to whether the health care provider furnishing the Emergency Health Care Services is a Network Provider or a Network Emergency Facility, as applicable, with respect to the services;
- If the Emergency Health Care Services are provided by an Out-of-Network Provider or Out-of-Network Emergency Facility, without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to Emergency Health Care Services received from Network Providers;
- Without limiting what constitutes an Emergency solely on the basis of diagnosis codes; and
- Without regard to any other term or condition of the coverage, other than:
  - Applicable cost-sharing; and
  - For Emergency Health Care Services provided for a condition that is not an Emergency, the exclusion or coordination of benefits.

Benefits include the facility charge, supplies and all professional services required to stabilize your condition and/or begin treatment. This includes placement in an observation bed to monitor your condition (rather than being admitted to a Hospital for an Inpatient Stay).

Benefits are provided for follow-up care when we authorize, direct, refer, or allow you to access a Hospital Emergency Facility or other Urgent Care Center for a medical condition that requires Emergency surgery. Such follow-up care is provided when services are:

- Medically Necessary;
- Directly related to the condition for which the surgical procedure was performed; and
- Provided in consultation with your Physician.

9. Enteral Nutrition

Benefits are provided for specialized enteral formulas administered either orally or by tube feeding for certain conditions under the direction of a Physician.

Benefits also include medical food for Covered Persons with metabolic disorders when ordered by a Physician qualified to provide diagnosis and treatment in the field of metabolic disorders.

Benefits for nutritional services include unlimited nutritional counseling and medical nutrition therapy.

10. Habilitative Services

For purposes of this Benefit, "habilitative services" means Skilled Care services and devices that are part of a prescribed treatment plan or Maintenance Program to help a person with a disability to keep, learn or improve skills and functioning for daily living. We will decide 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 disability are not considered habilitative services.

Benefits for habilitative services for the treatment of Congenital Anomaly or genetic birth defects, include services for cleft lip and cleft palate, orthodontics, oral surgery, otologic, and audiological therapy.

Habilitative services include:

- Physical therapy.
- Occupational therapy.
- Speech therapy.
- Post-cochlear implant aural therapy.
- Cognitive therapy.

Benefits are provided for habilitative services for both inpatient services and outpatient therapy when you have a disability when both of the following conditions are met:

- Treatment is administered by any of the following:

- Licensed speech-language pathologist.
- Licensed audiologist.
- Licensed occupational therapist.
- Licensed physical therapist.
- Physician.

- Treatment must be proven and not Experimental or Investigational.

The following are not habilitative services:

- Custodial Care.
- Respite care.
- Day care.
- Therapeutic recreation.
- Educational/vocational training.
- Residential Treatment.
- A service or treatment plan that does not help you meet functional goals.
- Services solely educational in nature.
- Educational services otherwise paid under state or federal law.

We may require the following be provided for the treatment of Autism Spectrum Disorder:

- A comprehensive evaluation of an individual by the individual's Primary Care Physician or specialty Physician;
- A prescription from an individual's Primary Care Physician or specialty Physician that includes specific treatment goals; and
- An annual review by the prescribing Primary Care Physician or specialty Physician, in consultation with the habilitative services provider, that includes:
  - Documentation of benefit to the individual;
  - Identification of new or continuing treatment goals; and
  - Development of a new or continuing treatment plan.

We may require the following be provided for all other conditions:

- Medical records.
- Other necessary data to allow us to prove that medical treatment is needed.

When the Treating Provider expects that continued treatment is or will be required to allow you to achieve progress we may request additional medical records.

Habilitative services provided in your home by a Home Health Agency are provided as described under *Home Health Care*.

Benefits for DME, Orthotics and prosthetic devices, when used as a part of habilitative services, are described under *Durable Medical Equipment (DME), Orthotics* and *Prosthetic Devices.*

11. Hearing Aids

Hearing Aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). These are electronic amplifying devices designed to bring sound more effectively into the ear. These consist of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased through a licensed audiologist, hearing aid dispenser, otolaryngologist, or other authorized provider. Benefits are provided for the hearing aid and associated fitting charges 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, we will pay only the amount that we would have paid for the hearing aid that meets the minimum specifications, and you will be responsible for paying any difference in cost.

Cochlear implants are not Hearing Aids. Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Services categories in this Policy. They are only available if you have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals prevent the use of a wearable hearing aid.
- Hearing loss severe enough that it would not be remedied by a wearable hearing aid.

12. Home Health Care

Services received from a Home Health Agency that are all of the following:

- Ordered by a Physician.
- Provided in your home by a registered nurse, or provided by a home health aide, home health therapist, or licensed practical nurse and supervised by a registered nurse.
- Provided on a part-time, Intermittent Care schedule.
- Provided when Skilled Care is required.
- Provides each patient with a planned program of observation and treatment by a Physician, in accordance with existing standards of medical practice for the Sickness or Injury requiring the Home Health Care.

For Covered Persons that received less than 48 hours of inpatient hospitalization following a mastectomy or removal of a testicle or who undergo a mastectomy or removal of a testicle on an outpatient basis will receive the following:

- One home visit scheduled to occur within 24 hours after discharge from the Hospital or outpatient health care facility; and
- An additional home visit if prescribed by the Covered Person’s attending Physician.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management.

13. Hospice Care

Hospice Care that is recommended by a Physician. Hospice Care is an integrated program that provides comfort and support services for the terminally ill. It includes the following:

- Physical, psychological, social, spiritual and respite care for the terminally ill person.
- Short-term grief counseling for immediate family members while you are receiving Hospice Care.

Benefits are available when you receive Hospice Care from a licensed hospice agency.

You can call us at the telephone number on your ID card for information about our guidelines for Hospice Care.

14. Hospital - Inpatient Stay

Services and supplies provided during an Inpatient Stay in a Hospital.

Benefits are available for:

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

15. Infertility Services

Benefits include:

- Diagnosis and treatment of infertility.

- Artificial insemination and intrauterine insemination, subject to the following conditions:
  - Have a history of the inability to conceive after one year of unprotected vaginal intercourse.
  - A fertility examination resulted in a Physician's recommendation advising artificial insemination or intrauterine insemination.

  Charges for collection of the Covered Person's sperm is not included unless the spouse is also a Covered Person.
- In vitro fertilization procedures performed on an outpatient basis, subject to the following conditions and limitations:
  - For a married Covered Person whose spouse is of the opposite sex, the oocytes of the Covered Person must be fertilized with the sperm of the Covered Person's spouse unless:
    - The Covered Person's spouse is unable to produce and deliver functional sperm; and
    - The inability to produce and deliver functional sperm is not the result of a vasectomy or another method of voluntary sterilization.
  - The married Covered Person and spouse must have experienced involuntary infertility that:
    - Is demonstrated by a history of:
      - For a Covered Person whose spouse is of the opposite sex, sexual intercourse failing to result in pregnancy for a duration of at least one year; or
      - For a Covered Person whose spouse is of the same sex, 3 attempts of artificial insemination over the course of one year failing to result in pregnancy; or
    - Is associated with any of the following medical conditions:
      - Endometriosis;
      - Exposure in utero to diethylstilbestrol (DES);
      - Blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy); or
      - Abnormal male factors, including oligospermia, contributing to the infertility.
  - The unmarried Covered Person:
    - Has had 3 attempts of artificial insemination over the course of one year failing to result in pregnancy; or
    - Is associated with any of the following medical conditions:
      - Endometriosis;
      - Exposure in utero to diethylstilbestrol (DES);
      - Blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy); or
      - Abnormal male factors, including oligospermia, contributing to the infertility.
  - The Covered Person has not been able to attain a successful pregnancy through a less costly infertility treatment that is a Covered Health Care Service.
  - The in vitro fertilization procedures must be performed at a medical facility that conforms to applicable guidelines or minimum standards issued by the American College of Obstetricians and Gynecologists or the American Society for Reproductive Medicine.

16. Lab, X-Ray and Diagnostic - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office include:

- Lab and radiology/X-ray.

- Mammography.
- Medically recognized diagnostic examinations for prostate cancer.

Benefits 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. Benefits are limited as described in the *Schedule of Benefits*.
- Follow-up diagnostic imaging to assist in the diagnosis of lung cancer.
- Diagnostic breast examination.
- Supplemental breast examination.

For purposes of breast examinations, diagnostic breast examination means a Medically Necessary and appropriate examination of the breast that is used to evaluate an abnormality that is:

- Seen or suspected from a prior screening examination for breast cancer; or
- Detected by another means of prior examination.

Diagnostic breast examination includes an examination using diagnostic mammography, breast magnetic resonance imaging, or breast ultrasound. Supplemental breast examination means a Medically Necessary examination of the breast that is used to screen for breast cancer when:

- There is no abnormality seen or suspected from a prior examination; and
- There is personal or family medical history or additional factors that may increase an individual’s risk of breast cancer.

Supplemental breast examination includes an examination using breast magnetic resonance imaging or breast ultrasound.

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

CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Major Diagnostic and Imaging - Outpatient*.

17. Major Diagnostic and Imaging - 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 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*.)

18. Manipulative Therapy

Benefits are provided for Manipulative Treatment (adjustment) including diagnostic and treatment services.

Benefits are limited as described in the Schedule of Benefits.

19. Medical Homes

Benefits for services provided by a Patient Centered Medical Home include chronic condition, serious Illness, or complex health care needs when participation in a Patient Centered Medical Home program.

Benefits include associated costs for coordination of care, such as:

- Liaison services between the Covered Person and the Provider, nurse coordinator, and the care coordination team.
- Creation and supervision of a care plan.
- Education of the Covered Person and family regarding the disease, treatment compliance, and self-care techniques.
- Assistance with coordination of care, including arranging consultations with specialists and obtaining Medically Necessary supplies and services, including community resources.

20. Mental Health Care and Substance-Related and Addictive Disorders Services

Mental Health Care and Substance-Related and Addictive Disorders Services include those received on an inpatient or outpatient basis in a Hospital, Residential Treatment facility, an Alternate Facility, in a provider's office, or via Telehealth/Telemedicine. All services must be provided by a behavioral health provider who is properly licensed and qualified by law, and acting within the scope of their licensure, which includes a licensed, registered or certified mental health and substance-related and addictive disorders practitioner, a licensed clinical professional counselor, a licensed clinical marriage and family therapist, a licensed clinical alcohol and drug counselor or a licensed clinical professional art therapist.

Benefits include the following levels of care:

- Inpatient treatment.
- Inpatient professional fees.
- Inpatient Residential Treatment.
- Partial Hospitalization or Intensive Day Treatment programs.
- Intensive Outpatient Treatment, including professional charges in a provider’s office or other professional setting.
- Outpatient treatment including diagnostic tests provided and billed by a licensed, registered or certified mental health and substance-related and addictive disorders practitioner, laboratory, Hospital, or other covered facility.
- Diagnosis and treatment of alcoholism and drug abuse, including detoxification treatment and counseling.

Inpatient Hospital and Inpatient Residential Treatment Facility services include: 1) room and board (including ward, Semi-private Room, or intensive care accommodations. 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); 2) general nursing care; and meals and special diets; and 3) other facility services and supplies for services provided by a Hospital or Residential Treatment Facility.

Services include those provided by a licensed, registered or certified mental health and substance-related and addictive disorders practitioner when acting within the scope of their license, registration or certification such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists, and include the following:

- Diagnostic evaluations, assessment and treatment planning (including psychological and neuropsychological testing for diagnosis purposes). This includes outpatient diagnostic tests provided and billed by a licensed, registered or certified mental health and substance-related and addictive disorders practitioner and outpatient diagnostic tests provided and billed by a laboratory, Hospital or other covered facility.
- Medication evaluation and management (pharmacotherapy).
- Individual, family, and group therapy.
- Treatment and counseling, including individual and group therapy visits.
- Crisis intervention and stabilization for acute episodes and Residential Crisis Services.
- Electroconvulsive therapy.
- Inpatient professional fees.
- Mental Health Care 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 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.

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

Benefits for outpatient services and supplies billed by a hospital for emergency room treatment are provided as described above under *Emergency Health Care Services – Outpatient*.

Benefits for Medically Necessary behavioral health care services provided by a participating provider will be covered when a Covered Person is a student and that service is provided at a public school or through a school-based health care center. In this instance, the following words have the meanings indicated below:

- "Behavioral health counseling services" means prevention, intervention and treatment services for the social-emotional, psychological, behavioral and physically health of students, including mental health and substance-related and addictive disorders.
- "Health care provider" has the meaning stated in *§20-104 of the Health – General Article*.

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

We encourage you to contact the Mental Health/Substance-Related and Addictive Disorders Designee for referrals to providers and coordination of care through the Internet at www.myuhc.com/exchanges or by calling the telephone number on your ID card.

21. Morbid Obesity Surgery

The plan covers surgical treatment of morbid obesity provided all of the following are true:

- You have a minimum Body Mass Index (BMI) greater than 40 kilograms per meter squared, or equal to or greater than 35 kilograms per meter squared with one of the following co-morbid conditions:
  - Hypertension;
  - A cardiopulmonary condition;
  - Sleep apnea; or
  - Diabetes.
- You must enroll in the Optum Bariatric Resource Services (BRS) program, a surgical weight loss solution for those individual(s) who qualify clinically for Morbid Obesity Surgery. Covered participants seeking coverage for bariatric surgery should notify Optum as soon as the possibility of a bariatric surgery procedure arises (and before the time a pre-surgical evaluation is performed) at a bariatric surgery center by calling Optum at (888) 936-7246 to enroll in the program.
- You have completed a multi-disciplinary surgical preparatory regimen, which includes a psychological evaluation.
- You have a 3-month Physician supervised diet documented within the last 2 years.

22. Necessary Medical Supplies

Medical Supplies that are used with covered DME are covered when the supply is necessary for the effective use of the item/device (e.g., oxygen tubing or mask, batteries for power wheelchairs and prosthetics, or tubing for a delivery pump).

Ostomy Supplies are also covered and limited to the following:

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

Note: Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above (check the member specific benefit plan document for coverage of Ostomy Supplies).

Urinary Catheters are also covered for external, indwelling and intermittent urinary catheters for incontinence or retention. Benefits include related urologic supplies for indwelling catheters limited to the following:

- Urinary drainage bag and insertion tray (kit).
- Anchoring device.
- Irrigation tubing set.

23. Orthotics

Orthotic devices means rigid or semi-rigid supportive devices that restrict or eliminate motion of a weak or diseased body part.

Orthotic braces such as for the leg, arm, neck and back, including needed changes to shoes to fit braces, braces that stabilize an injured body part and braces to treat curvature of the spine are a Covered Health Care Service.

Coverage will be provided for the training necessary to use the orthotic device.

Benefits are available for fitting, repairs and replacement, except as described in *Section 2: Exclusions and Limitations*.

24. Pharmaceutical Products - Outpatient

Pharmaceutical Products, including injectable drugs, and New Pharmaceutical Product, for Covered Health Care Services administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in your home.

Benefits are provided for Pharmaceutical Products which, due to their traits (as determined by us), are 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 Policy. Benefits for medication normally available by a prescription or order or refill are provided as described under *Section 10: Outpatient Prescription Drugs.*

If you require certain Pharmaceutical Products, including specialty Pharmaceutical Products, we may direct you to a Designated Dispensing Entity. 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 get your Pharmaceutical Product from a Designated Dispensing Entity, Benefits are not available for that Pharmaceutical Product, unless the provider or its intermediary agrees in writing to accept reimbursement, including copayment, at the same rate as a Designated Dispensing Entity.

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 us at www.myuhc.com/exchange or the telephone number on your ID card.

A step therapy requirement may not be imposed if:

- The step therapy drug has not been approved by the *U.S. Food and Drug Administration (FDA)* for the medical condition being treated; or
- The prescribing provider provides supporting medical information to us that a Prescription Drug Product:
  - Was ordered by a prescribing provider for the Covered Person within the past 180 days; and
  - Based on the professional judgment of the prescribing provider, was effective in treating the Covered Person’s medical condition.
- The prescription drug has been approved by the *FDA* and:
  - Is being used to treat the Covered Person’s stage four advanced metastatic cancer; and
  - Use of the prescription drug is consistent with the FDA-approved indication or the *National Comprehensive Cancer Network Drugs & Biologics Compendium* indication for the treatment of stage four advanced metastatic cancer; and

- Is supported by peer-reviewed medical literature.

We will have certain programs in which you receive an enhanced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You can access information on these programs by contacting us at www.myuhc.com/exchange or the telephone number on your ID card.

25. Physician Fees for Surgical and Medical Services

Physician fees for surgical procedures and other medical services received on an outpatient or inpatient basis in a Hospital, Related Institution, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls.

26. Physician's Office Services - Sickness and Injury

Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided regardless of whether the Physician's office is freestanding, located in a clinic or located in a Hospital.

Covered Health Care Services include medical education services that are provided in a Physician's office by appropriately licensed or registered health care professionals when both of the following are true:

- Education is required for a disease in which patient self-management is a part of treatment.
- There is a lack of knowledge regarding the disease which requires the help of a trained health professional.

Covered Health Care Services include:

- Genetic Counseling.
- Allergy testing, injections, and allergy serum.
- Medical nutrition therapy provided by a licensed dietician or nutritionist, working in coordination with a Physician, to treat a chronic illness or condition.
- Remote Physiologic Monitoring services.
- Objective second opinion given to a Covered Person when required by a utilization review program under Maryland law.
- Diagnosis and treatment of the underlying causes of infertility. Depending on where a service is received, Benefits will be provided under the corresponding Benefit category in this Policy.

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

Benefits for CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Major Diagnostic and Imaging - Outpatient.*

When a test is performed or a sample is drawn in the Physician's office, Benefits for the analysis or testing of a lab, radiology/X-ray or other diagnostic service, whether performed in or out of the Physician's office are described under *Lab, X-ray and Diagnostic - Outpatient.*

27. Pregnancy - Maternity Services

Benefits for Pregnancy include all maternity-related medical services for prenatal care, postnatal care, delivery and any related complications. Benefits include those of a certified nurse-midwife or pediatric nurse practitioner. Benefits include abortion care services which are not subject to the annual Deductible or any Co-payment or Co-insurance.

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 Care Services include related tests and treatment.

Benefits include birthing classes, one course per Pregnancy, at a facility approved by us.

We will pay Benefits for an Inpatient Stay of at least:

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

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames. In the event of such a shorter stay, we will provide Benefits for at least one home care visit, which will occur within 24 hours following discharge, as described above under *Home Health Care*. An additional home care visit will be covered if prescribed by the Physician. If the mother and newborn child remain in the Hospital for at least as long as the minimum Inpatient Stay shown above, a single home visit will be provided if prescribed by the attending Physician as described above under Home Health Care.

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

28. Preventive Care Services

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

- Evidence-based items or services, inclusive of current recommendations for breast cancer, that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force.* Note that recommendations of the *United States Preventive Services Task Force* regarding breast cancer screening, mammography and prevention issued in or around November 2009 are not considered to be current.
- Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.*
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration.*
- Prostate cancer screening including digital rectal exams and prostate-specific antigen (PSA) blood tests for:
  - Male Covered Persons who are between the ages of 40 and 75; or
  - When used for the purpose of guiding patient management in monitoring the response to prostate cancer treatment; or
  - When used for staging in determining the need for a bone scan in patients with prostate cancer; or
  - When used for Covered Persons who are at high risk for prostate cancer.
- Wellness Benefits will be provided for:
  - A health risk assessment that is completed by a Covered Person on a voluntary basis; and
  - Written feedback to the individual who completes the health risk assessment, with recommendations for lowering risks identified in the completed health risk assessment.

Benefits defined under the *Health Resources and Services Administration (HRSA)* requirement include one breast pump per Pregnancy in conjunction with childbirth. Breast pumps must be ordered by or provided by a Physician. You can find more information on how to access Benefits for breast pumps by contacting us at www.myuhc.com/exchange or the telephone number on your ID card.

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

- Which pump is the most cost-effective.
- Whether the pump should be purchased or rented (and the duration of any rental).
- Timing of purchase or rental.

Family Planning

Family planning services include the following:

- Prescription contraceptive drugs or devices;

- Coverage for the insertion or removal of contraceptive devices;
- Medically Necessary examination associated with the use of contraceptive drugs or devices; and
- Voluntary female or male sterilization, including associated anesthesia.

29. Prosthetic Devices

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

- Artificial arms, legs, feet and hands.
- Artificial face, eyes, ears and nose.
- Breast prosthesis and mastectomy bras for Covered Persons undergoing treatment for cancer.
- One hair prosthetic/wig when prescribed by a provider.

Benefits are provided only for external prosthetic devices and do not include any device that is fully implanted into the body. Internal prosthetics are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Service categories in this Policy.

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

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

Coverage will be provided for the training necessary to use the prosthetic device.

Benefits are available for fitting, repairs and replacement.

30. Reconstructive Procedures

Reconstructive procedures when the primary purpose of the procedure is either of the following:

- Treatment of a medical condition.
- Improvement or restoration of physiologic function.

Reconstructive procedures include surgery or other procedures which are related to an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance. Microtia repair is considered a reconstructive procedure.

Cosmetic Procedures are excluded from coverage. Cosmetic Procedures do not include reconstructive procedures for treatment of a Congenital Anomaly of a newborn child. The fact that you 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. Medical and surgical treatment of excessive sweating (hyperhidrosis) is considered a Cosmetic Procedure.

Please note that Benefits for reconstructive procedures include Reconstructive Breast Surgery, including for all stages of Reconstructive Breast Surgery performed on a non-affected breast to establish symmetry with the diseased breast. In addition, physical complications of all stages of mastectomy, including lymphedemas, will be covered as determined in consultation with the attending Physician and the patient. You can call us at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

31. Rehabilitation Services - Outpatient Therapy

Short-term outpatient rehabilitation services limited to:

- Physical therapy.
- Occupational therapy.
- Speech therapy.
- Pulmonary rehabilitation therapy.

- Cardiac rehabilitation therapy. Benefits include continuous EKG telemetric monitoring during exercise, EKG rhythm strip with interpretation, Physician's revision of exercise prescription, and follow-up exam for Physician to adjust medication or change regimen.
- Post-cochlear implant aural therapy.
- Cognitive rehabilitation therapy.

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Rehabilitative services provided in your home by a Home Health Agency are provided as described under *Home Health Care*.

The goal of outpatient rehabilitation therapy is to return the individual to his/her prior skill and functional level.

For the purpose of this Benefit, "cardiac rehabilitation" is a comprehensive program involving medical evaluation, prescribed exercise, cardiac risk factor modification, education and counseling.

Benefits can be denied or shortened when either of the following applies:

- You are not progressing in goal-directed rehabilitation services.
- Rehabilitation goals have previously been met.

Benefits are not available for maintenance/preventive treatment.

32. Scopic Procedures - Outpatient Diagnostic and Therapeutic

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

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

- Colonoscopy.
- Sigmoidoscopy.
- Diagnostic endoscopy.

Please note that Benefits do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*.

Benefits include:

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

Benefits that apply to certain preventive screenings are described under *Preventive Care Services*.

33. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Services and supplies provided during an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Benefits are available for:

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

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

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

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management and will be covered as an alternative to Medically Necessary inpatient hospital services.

Benefits can be denied or shortened when either of the following applies:

- You are not progressing in goal-directed rehabilitation services.
- Discharge rehabilitation goals have previously been met.

34. Surgery - Outpatient

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

Benefits include certain scopic procedures. Examples of surgical scopic procedures include:

- Arthroscopy.
- Laparoscopy.
- Bronchoscopy.
- Hysteroscopy.

Benefits 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*.)

Tissue transplants and cornea transplants when ordered by a Physician. Benefits are available for tissue and cornea transplants when the transplant meets the definition of a Covered Health Care Service, and is not an Experimental or Investigational or Unproven Service. You can call us at the telephone number on your ID card for information regarding Benefits for tissue and cornea transplant services.

35. Telehealth

Benefits are provided for services delivered via Telehealth/Telemedicine. Benefits for these services are provided to the same extent as an in-person service under any applicable Benefit category in this section unless otherwise specified in the *Schedule of Benefits*.

Telehealth/Telemedicine - interactive audio only conversations between a health care provider and a Covered Person that results in the delivery of a billable, Covered Health Care Service, video, or other telecommunications or electronic technology by a health care provider to deliver a Covered Health Care Service that is within the scope of practice of the health care provider at a location other than the location at which the patient is located regardless of the location of the patient at the time the Telehealth/Telemedicine services are provided. Telehealth/Telemedicine does not include audio-only telephone conversation (except as noted above), facsimile, texting, instant message, electronic mail or virtual care services provided by a Designated Virtual Network Provider.

36. Temporomandibular Joint Syndrome (TMJ)

Benefits include charges for Covered Health Care Services to diagnose and treat temporomandibular joint and craniomandibular disorders when treatment is needed for:

- Accidental damage.
- Trauma.
- Congenital Anomaly.
- Developmental defect.
- Pathology.

Benefits include services for diagnostic and surgical treatment that is recognized by us as a generally accepted form of care or treatment, according to prevailing standards of the medical and dental practice profession as effective and appropriate for the diagnosis and surgical treatment of temporomandibular joint and craniomandibular disorders.

37. Therapeutic Treatments - Outpatient

Therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including:

- Dialysis (both hemodialysis and peritoneal dialysis).
- Intravenous Chemotherapy or other intravenous Infusion Therapy.
- Radiation oncology.
- Blood, Blood Products, derivatives, components, biologics, and serums to include autologous services, whole blood, red blood cells, platelets, plasma, immunoglobin and albumin.

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

- Education is required for a disease in which patient self-management is a part of treatment.
- There is a lack of knowledge regarding the disease which requires the help of a trained health professional.

Benefits include:

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

38. Transplantation Services

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

Coverage will be provided for all Medically Necessary solid organ transplants and non-solid organ transplant procedures. Examples of transplants for which Benefits are available include:

- Bone marrow.
- Heart.
- Heart/lung.
- Lung.
- Kidney.
- Kidney/pancreas.
- Liver.
- Liver/small intestine.
- Pancreas.
- Small intestine.

Donor costs related to transplantation are Covered Health Care Services and are payable through the organ recipient's coverage under this Policy, limited to donor:

- Identification.
- Evaluation.
- Organ removal.
- Direct follow-up care.

Benefits include the cost of hotel lodging and air transportation for the recipient Covered Person and a companion (or the Covered Person and two companions if the Covered Person is under the age of 18 years), to and from the site of the transplant.

You can call us at the telephone number on your ID card for information about our specific guidelines regarding Benefits for transplant services.

39. Urgent Care Center Services

Covered Health Care Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services - Sickness and Injury*.

40. Virtual Care Services

Virtual care for Covered Health Care Services that includes the diagnosis and treatment of less serious medical conditions. Virtual care provides communication of medical information in real-time between the patient and a distant Physician or health specialist, 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 contacting us at www.myuhc.com/exchange or the telephone number on your ID card.

Benefits are available for Primary care, which is general and non-emergency care, delivered through live audio with video or audio only technology from a Primary Care Physician.

Benefits are available for Urgent on-demand health care delivered through live audio with video or audio only technology for treatment of acute but non-emergency medical needs.

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

Benefits do not include email or fax, or for services that occur within medical facilities (*CMS* defined originating facilities).

Section 2: Exclusions and Limitations

We Do Not Pay Benefits for Exclusions

We will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

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

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

Where Are Benefit Limitations Shown?

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

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

Exclusions

1. Services that are not Medically Necessary.
2. Services performed or prescribed under the direction of a person who is not a Provider.
3. Services that are beyond the scope of practice of a Provider performing the service.
4. Services to the extent they are covered by any government unit, except for veterans in Veterans' Administration or armed forces facilities for services received for which the recipient is liable.
5. Services for which a Covered Person is not legally, or as a customary practice, required to pay in the absence of a health benefit plan.
6. The purchase, exams, or fitting of eyeglasses or contact lenses, except for aphakic patients soft or rigid gas permeable lenses or sclera shells intended for use in the treatment of a disease or Injury. This exclusion does not apply to the Benefits provided for pediatric vision as described in *Section 12: Pediatric Vision Care Services*.
7. Personal Care services and Domiciliary Care services.
8. Services rendered by a health care practitioner who is a Covered Person's spouse, mother, father, daughter, son, brother, or sister.
9. Experimental Services.
10. Practitioner, Hospital, or clinical services related to radial keratotomy, myopic keratomileusis, and surgery that involve corneal tissue for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error.
11. Services to reverse a voluntary sterilization procedure.
12. Services for sterilization or reverse sterilization for a dependent minor. This exclusion does not apply to *USFDA* approved sterilization procedures for women with reproductive capacity.
13. Medical or surgical treatment or regimen for reducing or controlling weight, unless otherwise specified in *Section 1: Covered Health Care Services*.
14. Services incurred before the effective date of coverage for a Covered Person.
15. Services incurred after a Covered Person's termination of coverage, including any extension of Benefits.
16. Surgery or related services for Cosmetic Procedures to improve appearance, but not to restore bodily function or correct deformity resulting from disease, trauma, or Congenital or developmental Anomalies.

17. Services for Injuries or diseases related to a Covered Person's job to the extent the Covered Person is required to be covered by a workers' compensation law.
18. Services rendered from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar persons or groups.
19. Personal hygiene and convenience items including, but not limited to, air conditioners, humidifiers, or physical fitness equipment.
20. Charges for telephone consultations except a covered Telehealth/Telemedicine consultation, failure to keep a scheduled visit, or completion of any form.
21. Inpatient admissions primarily for diagnostic studies, unless authorized by us.
22. Except for covered ambulance services, travel, whether or not recommended by a health care practitioner. This exclusion does not apply to travel for transplantation services for which Benefits are provided as described in *Section 1: Covered Health Care Services* under *Transplantation Services*.
23. Except for Emergency Health Care Services, services received while the Covered Person is outside the United States.
24. Immunizations related to foreign travel.
25. Unless otherwise specified in *Section 1: Covered Health Care Services* or in *Section 11: Pediatric Dental Care Services*, dental work or treatment which includes hospital or professional care in connection with:
    a) The operation or treatment for the fitting or wearing of dentures,
    b) Orthodontic care or malocclusion,
    c) Operations on or for treatment of or to the teeth or supporting tissues of the teeth, except for removal of tumors and cysts or treatment of injury to natural teeth due to an accident if treatment is started within six months of the accident, or if not a Covered Person at the time of the accident, within the first six months of coverage under the Policy unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care); and
    d) Dental implants.
26. Accidents occurring while and as a result of chewing. This exclusion does not apply to the Benefits provided for pediatric dental services as described in *Section 11: Pediatric Dental Care Services*.
27. Routine foot care, including the paring or removing of corns and calluses, or trimming of nails, unless these services are determined to be Medically Necessary.
28. Arch support, orthotic devices, in-shoe supports, orthopedic shoes, elastic supports, or exams for their prescription or fitting. This exclusion does not apply to items for which Benefits are provided as described under *Diabetes Services*, *Durable Medical Equipment (DME)*, and *Orthotics* in *Section 1: Covered Health Care Services*.
29. Inpatient admissions primarily for physical therapy, unless authorized by us.
30. Treatment of sexual dysfunction not related to organic disease.
31. Services that duplicate benefits provided under federal, State, or local laws, regulations, or programs.
32. Nonhuman organs and their implantation.
33. Non-replacement fees for blood and blood products.
34. Lifestyle improvements, including nutrition counseling, or physical fitness programs, unless included as a Covered Health Care Service.
35. Wigs or cranial prosthesis, unless otherwise specified in *Section 1: Covered Health Care Services*.
36. Weekend admission charges, except for emergencies and maternity, unless authorized by us.
37. Outpatient orthomolecular therapy, including nutrients, vitamins, and food supplements.
38. Temporomandibular joint syndrome (TMJ) treatment and treatment for craniomandibular pain syndrome (CPS), except for surgical services for TMJ and CPS, if Medically Necessary and if there is a clearly demonstrable radiographic evidence of joint abnormality due to disease or injury.

39. Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.
40. Services for conditions that State or local laws, regulations, ordinances, or similar provisions require to be provided in a public institution.
41. Services for, or related to, the removal of an organ from a Covered Person for purposes of transplantation into another person, unless the:
    a) Transplant recipient is covered under the plan and is undergoing a covered transplant, and
    b) Services are not payable by another carrier.
42. Physical exams required for obtaining or continuing employment, insurance or government licensing.
43. Nonmedical ancillary services such as vocational rehabilitation, employment counseling, or educational therapy.
44. Private hospital room, unless authorized by us.
45. Private Duty Nursing, unless authorized by us.
46. Treatment for Mental Health or Substance-Related Addictive Disorder Services, for the following:
    a) Services for pastoral or marital counselors.
    b) Therapy for sexual problems.
    c) Treatment for learning disabilities or intellectual disabilities.
    d) Travel time to the Covered Person's home to conduct therapy.
    e) Services rendered or billed by a school, or halfway houses or members of their staff.
    f) Marriage counseling.
    g) Services not Medically Necessary.
47. Cardiac rehabilitation therapy and pulmonary rehabilitation therapy services provided at a place of service that is not equipped and approved to provide such therapies.
48. Cardiac rehabilitation therapy and pulmonary rehabilitation therapy provided as maintenance programs. Maintenance programs consist of activities that preserve the individual's present level of function and prevent regression of that function. Maintenance begins when therapeutic goals of a treatment plan have been achieved, or when no additional progress is apparent or expected to occur.
49. Payment of any claim, bill, or other demand or request for payment for health care services that the appropriate regulatory board determines was provided as a result of a prohibited referral. "Prohibited referral" means a referral prohibited by *1-302 of the Maryland Health Occupations Article*.

Section 3: When Coverage Begins and Premiums

How Do You Enroll?

Eligible Persons must complete enrollment and make the required Premium payment, as determined by the Maryland Health Benefit Exchange. We will not provide Benefits for health care services that you receive before your effective date of coverage.

What If You Are Hospitalized When Your Coverage Begins?

We will pay Benefits for Covered Health Care Services when all of the following apply:

- You are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins.
- You receive Covered Health Care Services on or after your first day of coverage related to that Inpatient Stay.
- You receive Covered Health Care Services in accordance with the terms of this Policy.

These Benefits are subject to your previous carrier's obligations under state law or contract.

You should notify us of your hospitalization within 48 hours of the day your coverage begins, or as soon as reasonably possible. Network Benefits are available only if you receive Covered Health Care Services from Network Providers, except for those instances described in your *Schedule of Benefits* under the heading “Continuity of Care”.

Who Is Eligible for Coverage?

The Maryland Health Benefit Exchange determines who is eligible to enroll and who qualifies as a Dependent.

Eligible Person

Eligible Person refers to a person who meets the eligibility rules as verified by the Maryland Health Benefit Exchange. When an Eligible Person actually enrolls, we refer to that person as a Policyholder. For a complete definition of Eligible Person and Policyholder, see *Section 8: Defined Terms*.

Eligible Persons must live within the Service Area, unless otherwise provided by the Maryland Health Benefit Exchange.

Dependent

Dependent generally refers to the Policyholder's spouse and children. When a Dependent enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see *Section 8: Defined Terms*.

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

When Do You Enroll and When Does Coverage Begin?

Except as described below, Eligible Persons may not enroll themselves or their Dependents.

Annual Open Enrollment Period

The open enrollment period is the period of time when Eligible Persons can enroll themselves and their Dependents, as determined by the Maryland Health Benefit Exchange.

Coverage begins on the date determined by the Maryland Health Benefit Exchange if we receive the completed enrollment materials and the required Premium.

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period, as determined by the Maryland Health Benefit Exchange. Except as otherwise specified below, an individual not currently enrolled in a Qualified Health Plan may enroll in any Qualified Health Plan. An individual currently enrolled in a Qualified Health Plan may enroll with his or her dependents in another Qualified Health Plan within the same level of coverage or one metal level higher or lower, if no such Qualified Health Plan is available. A non-covered dependent of an individual currently enrolled in a Qualified Health Plan may be added to the individual’s current Qualified Health Plan or may

enroll in any separate Qualified Health Plan. If our business rules for the current Qualified Health Plan do not allow for the dependent(s) to be enrolled in the same Qualified Health Plan, we must allow the enrolled individual and the non-covered dependent(s) to enroll in a different Qualified Health Plan within the same metal level or, if no such Qualified Health Plan is available, one metal level higher or lower. An individual who is not an enrollee and has one or more dependents who are enrollees who do not also qualify for a special enrollment period may enroll in the dependent's current Qualified Health Plan or may enroll in any separate Qualified Health Plan. If our business rules do not allow for the qualified individual to enroll in the dependent's current Qualified Health Plan, we must allow the individual to enroll with the dependent(s) in another Qualified Health Plan within the same metal level or one metal level higher or lower if no such Qualified Health Plan is available.

For the purpose of this provision, a "qualified individual" is an individual who has been determined eligible to enroll in a Qualified Health Plan through the Maryland Health Benefit Exchange.

The Maryland Health Benefit Exchange will allow qualified individuals or Dependents to enroll in or change from one Qualified Health Plan to another as a result of the following triggering events:

- Loss of minimum essential coverage.

  Loss of minimum essential coverage does not include loss due to:

  - Failure to pay Premiums on a timely basis, including COBRA premium prior to the expiration of COBRA coverage, except for circumstances in which an employer completely ceases its contributions to COBRA continuation coverage or government subsidies of COBRA continuation coverage completely cease;
  - Situations allowing for rescission of coverage (the individual performs an act, practice, or omission that constitutes fraud, or the individual makes an intentional misrepresentation of material fact); or
  - Voluntary termination.

- End of policy year for a qualified individual covered under a non-calendar year group health plan, individual health insurance plan, or qualified small employer health reimbursement arrangement (QSEHRA), even if an individual or Dependent has the option to renew or re-enroll in such coverage. The date of the loss of coverage is the last day of the plan or policy year.

- Loss of pregnancy related coverage by a qualified individual or Dependent under the Social Security Act (Medicaid) or loss of access to health care services through coverage provided to a pregnant woman's unborn child.

- Loss of medically needy coverage as described under the Social Security Act only once per calendar year.

- A qualified individual gains a Dependent or becomes a Dependent through marriage, birth, adoption, placement for adoption, or placement in foster care, or through a child support order or other court order. In the case of marriage, the qualified individual meeting the prior coverage requirement (as described further below) for one or more days during the 60 days preceding the date of the marriage.

  For purposes of this triggering event, a qualified individual not currently enrolled in a Qualified Health Plan may enroll in any Qualified Health Plan. A qualified individual currently enrolled in a Qualified Health Plan may add a Dependent to the same Qualified Health Plan or enroll a Dependent in any separate Qualified Health Plan.

- A qualified individual's or Dependent's enrollment or non-enrollment in a Qualified Health Plan is, as evaluated and determined by the Maryland Health Benefit Exchange:

  - Unintentional, inadvertent, or erroneous; and
  - The result of the error, misrepresentations, misconduct, or inaction of an officer, employee, or agent of the Maryland's Health Benefit Exchange or the U.S. Department of Health and Human Services (HHS) or its instrumentalities, or a non-Exchange entity providing enrollment assistance or conducting enrollment activities;

  In these circumstances, the Maryland Health Benefit Exchange may take action as may be necessary to correct or eliminate the effects of the error, misrepresentation, misconduct, or inaction.

  For purposes of this triggering event, a qualified individual or Dependent may enroll in or change to any Qualified Health Plan, regardless of whether the qualified individual or Dependent is currently enrolled in a Qualified Health Plan.

- A qualified individual or Dependent adequately demonstrates to the Maryland Health Benefit Exchange that the Qualified Health Plan in which the individual or Dependent is enrolled substantially violated a material provision of the Qualified Health Plan's contract in relation to the individual or Dependent.
- A qualified individual or Dependent's enrollment in a Qualified Health Plan was influenced by a material error related to plan benefits, service area, cost-sharing or premium. A material error is one that is likely to have influenced the qualified individual or Dependent's decision to purchase a Qualified Health Plan through the Maryland Health Benefit Exchange. For plans offered through the Maryland Health Benefit Exchange, a qualified individual or Dependent may enroll in or change to a Qualified Health Plan, regardless of whether the qualified individual or Dependent is currently enrolled in a Qualified Health Plan.
- A qualified individual or Dependent is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, including:
    - A qualified individual or Dependent enrolled in the same Qualified Health Plan is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions:
        - A qualified individual or Dependent newly eligible for cost-sharing reductions and not enrolled in a silver-level Qualified Health Plan may enroll only in a silver-level Qualified Health Plan.
        - A qualified individual or Dependent newly ineligible for cost-sharing reductions and enrolled in a silver-level Qualified Health Plan may enroll in a Qualified Health Plan one level higher or lower.
        - A qualified individual or Dependent newly eligible for advance payments of the premium tax credit is subject to the general enrollment restrictions described above.
        - A qualified individual or Dependent newly ineligible for advance payments of the premium tax credit may enroll in a Qualified Health Plan of any metal level, if the individual or Dependent elect to change their Qualified Health Plan enrollment.
    - A qualified individual or Dependent who is enrolled in an eligible employer-sponsored plan is determined newly eligible for advance payments of the premium tax credit based in part on a finding that such individual is ineligible for qualifying coverage in an eligible-employer sponsored plan in accordance with 26 CFR 1.36B-2(c)(3), including as a result of his or her employer discontinuing or changing available coverage within the next 60 days, provided that such individual is allowed to terminate existing coverage.
    - A qualified individual or Dependent who was previously ineligible for advance payments of the premium tax credit solely because of a household income below 100% of the federal poverty level and who, during the same timeframe, was ineligible for Medicaid because he or she was living in a non-Medicaid expansion state, who either experiences a change in household income or moves to a different state resulting in the qualified individual becoming eligible for advance payments of the premium tax credit.
    - A qualified individual or Dependent experiences a decrease in household income, is determined newly eligible by the Maryland Health Benefit Exchange for advance payments of the premium tax credit, and can demonstrate having minimum essential coverage for one or more days during the 60 days preceding the date of the financial change.
- A qualified individual or Dependent newly gains access to an individual coverage HRA (as defined in 45 CFR 146.123(b)) or is newly provided a qualified small employer health reimbursement arrangement (QSEHRA) (as defined in section 9831 (d)(2) of the Internal Revenue Code). For plans offered through the Maryland Health Benefit Exchange, an individual or Dependent may enroll in or change to a Qualified Health Plan, regardless of whether the individual or Dependent is currently enrolled in a Qualified Health Plan.
- A qualified individual or Dependent is enrolled in COBRA continuation coverage for which an employer is paying all or part of the premiums, or for which a government entity is providing subsidies, and the employer completely ceases its contributions to the qualified individual's or Dependent's COBRA continuation coverage or government subsidies completely cease. The triggering event is the last day of the period for which COBRA continuation coverage is paid for or subsidized, in whole or in part, by an employer or government entity.
- A qualified individual provides satisfactory documentary evidence to verify his or her eligibility for an insurance affordability program or enrollment in a Qualified Health Plan through the Maryland Health Benefit Exchange following termination of enrollment due to a failure to verify such status within the time period specified in 45 CFR 155.315 or is under 100% of the federal poverty level and did not enroll in coverage while waiting for HHS to verify his or her citizenship, status as a national, or lawful presence.

- A qualified individual or Dependent gains access to a new Qualified Health Plan as a result of a permanent move and can demonstrate meeting the prior coverage requirement for one or more days in the 60 days preceding the date of the move (as described further below).
- A qualified individual or Dependent who is not previously a citizen, national, or lawfully present individual becomes a citizen, national, or lawfully present individual or is released from incarceration.
- A qualified individual or Dependent demonstrates to the Maryland Health Benefit Exchange, in accordance with guidelines issued by the HHS, that the qualified individual meets other exceptional circumstances as the Maryland Health Benefit Exchange may provide. For purposes of this triggering event, a qualified individual or Dependent may enroll in or change to any Qualified Health Plan, regardless of whether the qualified individual or Dependent is currently enrolled in a Qualified Health Plan.
- An Indian, as defined by the Indian Health Care Improvement Act, or a Dependent who is enrolling on the same application as the Indian may enroll in a Qualified Health Plan or change from one Qualified Health Plan to another one time per month.
- A qualified individual loses a Dependent or is no longer a Dependent through divorce or legal separation as defined by state law in the state in which the divorce or legal separation occurs, or if the qualified individual or Dependent, dies.
- A qualified individual is a victim of domestic abuse or spousal abandonment or a Dependent or unmarried victim within a household, is enrolled in minimum essential coverage, and seeks to enroll in coverage separate from the perpetrator of the abuse or abandonment or is a Dependent of a victim of domestic abuse or spousal abandonment, on the same application as the victim, and seeks to enroll in coverage at the same time as the victim. For plans offered through the Maryland Health Benefit Exchange, an individual or Dependent may enroll in or change to a Qualified Health Plan, regardless of whether the individual or Dependent is currently enrolled in a Qualified Health Plan.
- A qualified individual applies for coverage on the Maryland Health Benefit Exchange during the annual open enrollment period or due to a qualifying event, is assessed by the Maryland Health Benefit Exchange as potentially eligible for Medicaid or for the Children's Health Insurance Program (CHIP) and is determined ineligible for Medicaid or CHIP by the State Medicaid or CHIP agency either after open enrollment has ended or more than 60 days after the qualifying event or applies for coverage at the State Medicaid or CHIP agency during the annual open enrollment period, and is determined ineligible for Medicaid or CHIP after open enrollment has ended.
- A qualified individual or Dependent who loses minimum essential coverage and whose loss of coverage is a loss of Medicaid or the Children's Health Insurance Program (CHIP) will have 90 days after the triggering event to select a Qualified Health Plan. If a State Medicaid or CHIP agency allows or provides for a Medicaid or CHIP reconsideration period greater than 90 days, the Maryland Health Benefit Exchange may elect to provide a qualified individual or their Dependents additional time to select a Qualified Health Plan, up to the number of days provided for the applicable Medicaid or CHIP reconsideration period.
- A qualified individual or Dependent who becomes pregnant may enroll in a Qualified Health Plan as of the date of Provider confirms the pregnancy.

Qualified individuals who are required to demonstrate having minimum essential coverage in the 60 days prior to a triggering event (i.e., those becoming or gaining a Dependent through marriage, pregnancy related coverage, unborn child coverage, medically needy coverage, and those gaining access to a new Qualified Health Plan as the result of a permanent move) can do so by demonstrating:

- They had minimum essential coverage for one or more days during the 60 days preceding the date of the triggering event;
- They had pregnancy related coverage or access to healthcare services through unborn child coverage for one or more day during the 60 days preceding the date of the triggering event;
- They had medically needy coverage for one or more days during the 60 days preceding the date of the triggering event;
- They are an Indian, as defined by the Indian Health Care Improvement Act;
- They lived in a foreign country or in a United States territory for one or more days during the 60 days preceding the move; or

- For one or more days during the 60 days preceding the triggering event or during their most recent preceding open enrollment or special enrollment period, lived in a service area where no Qualified Health Plan was available through the Maryland Health Benefit Exchange.

Effective Dates for Special Enrollment:

- For birth, adoption, or placement for adoption coverage is effective on the date of birth, adoption, placement for adoption. For placement in foster care, coverage is effective on the date of placement in foster care, the effective date of the court order or, if permitted by the Maryland Health Benefit Exchange, the individual may elect a coverage effective date of the first day of the month following plan selection or in accordance with 45 CFR 155.420(b)(1).
- For marriage, coverage is effective on the first day of the month following plan selection.
- For cases when: 1) the qualified individual or Dependent loses minimum essential coverage, including due to an employer completely ceasing its contributions to COBRA continuation overage or governmental subsidies of COBRA continuation coverage completely ceasing; 2) the qualified individual or Dependent who is enrolled in an eligible employer-sponsored plan is determined newly eligible for advance payments of the premium tax credit as a result of his or her employer discontinuing or changing available coverage and is allowed to terminate existing coverage; 3) the qualified individual or Dependent becomes newly eligible for advance payments of the premium tax credit due to a move from a non-Medicaid expansion State; 4) the qualified individual or Dependent gains access to a Qualified Health Plan as a result of a permanent move; 5) the qualified individual or Dependent loses pregnancy-related coverage; 6) the qualified individual or Dependent loses unborn child coverage; 7) the qualified individual or Dependent loses medically needy coverage; 8) the qualified individual or Dependent loses coverage under a non-calendar year group or individual plan; or 9) the qualified individual or Dependent becomes newly eligible due to release from incarceration the effective date is as follows:
    - If plan selection is made on or before the date of the triggering event, the Maryland Health Benefit Exchange must ensure coverage is effective on the first day of the month following the date of the triggering event;
    - If plan selection is made after the date of the triggering event, coverage will become effective as described in the last bullet of this section or, at the option of the Maryland health Benefit Exchange, coverage is effective on the first day of the following month; or
    - For the triggering events which results in a loss of minimum essential coverage, if plan selection is made on or before the last day of the month preceding the triggering event, the Maryland Health Benefit Exchange must ensure the coverage effective date is the first day of the month in which the triggering event occurs.
- For cases when: 1) the enrollment or non-enrollment was unintentional, inadvertent or erroneous and the result of error, misrepresentation, misconduct, or inaction by the Maryland Health Benefit Exchange or HHS; its instrumentalities, or a non-Exchange entity providing enrollment assistance or conducting enrollment activities; 2) the Qualified Health Plan substantially violated a material provision of its contract; 3) the qualified individual or Dependent adequately demonstrates that a material error related to plan benefits, service area, or premium influenced their decision; 4) the qualified individual or Dependent applied for coverage during the annual open enrollment period or due to a qualifying event is assessed as potentially eligible for Medicaid or CHIP and is determined ineligible for Medicaid or CHIP by the State Medicaid or CHIP agency either after open enrollment has ended or more than 60 days after the qualifying event or the qualified individual or Dependent applies for coverage at the State Medicaid or CHIP agency during the annual open enrollment period and is determined ineligible for Medicaid or CHIP after open enrollment has ended; 5) the qualified individual provides satisfactory documentary evidence to verify his or her eligibility for an insurance affordability program or enrollment in a Qualified Health Plan following termination of enrollment due to failure to verify such status within the time period specified in 45 CFR 155.315 or is under 100% of federal poverty level and did not enroll in coverage while waiting for HHS to verify his or her citizenship, status as a national, or lawful presence; 6) the individual meets other exceptional circumstances, the Maryland Health Benefit Exchange must ensure that coverage is effective on an appropriate date based on the circumstances of the special enrollment period.
- For a qualified individual or Dependent who newly gains access to an individual coverage HRA or is newly provided a QSEHRA and if the plan selection is made before the day of the triggering event, the effective date is on the first day of the month following the date of the triggering event or, if the triggering event is on the first day of a month, on the date of the triggering event. If plan selection is made on or after the date of the triggering event, the effective date is on the first day of the month following plan selection.
- For a qualified individual who gains a Dependent or becomes a Dependent through a child support order or other court order, coverage is effective on the date the court order is effective or if permitted by the Maryland Health

Benefit Exchange, the individual may elect a coverage effective date of the first day of the month following plan selection or in accordance with 45 CFR 155.420(b)(1).

- In the event of a qualified individual's death, coverage is effective on the first day of the month following plan selection or, if permitted by the Maryland Health Benefit Exchange, the individual may elect a coverage effective date of the first day of the following month when a selection is received between the first and fifteenth day of any month; and the first day of the second following month when a selection is received between the sixteenth and the last day of any month.
- For a qualified individual or Dependent who becomes pregnant as confirmed by a Provider, coverage is effective on the first day of the month in which the qualified individual receives confirmation of pregnancy by a Provider.
- For all other triggering events: When selection is made between the first and fifteenth day of any month, coverage is effective on the first day of the following month. When selection is made between the sixteenth and the last day of the month, coverage is effective the first day of the second following month.

Length of Special Enrollment Periods:

- Unless stated otherwise in this section, a qualified individual or Dependent has 60 days after the date of the triggering event to select a Qualified Health Plan.
- A qualified individual or Dependent who: 1) loses minimum essential coverage; 2) is enrolled under a non-calendar year group health plan, qualified small employer health reimbursement arrangement (QSEHRA), or individual health insurance plan; 3) loses pregnancy related coverage under section 1902(a)(10)(A)(i)(IV) and (a)(10)(A)(ii)(IX) of the Social Security Act (Medicaid) or loses access to health care services through coverage provided to a pregnant woman's unborn child; or 4) loses medically needy coverage as described under the Social Security Act only once per calendar year, has 60 days before and after loss of coverage to select a Qualified Health Plan.
- A qualified individual or Dependent who was previously ineligible for advance payments of the premium tax credit solely because of a household income below 100 percent of the FPL and who, during the same timeframe, was ineligible for Medicaid because he or she was living in a non-Medicaid expansion state, who either experiences a change in household income or moves to a different state resulting in the qualified individual or Dependent becoming newly eligible for advance payments of the premium tax credit has 60 days before and 60 days after the triggering event to select a Qualified Health Plan.
- A qualified individual or Dependent who is enrolled in COBRA continuation coverage for which an employer is paying all or part of the premiums, or for which a government entity is providing subsidies, and the employer completely ceases its contributions to the qualified individual or Dependent's COBRA continuation coverage or government subsidies completely cease has 60 days before and 60 days after the triggering event to select a Qualified Health Plan.
- A qualified individual or Dependent who is enrolled in an eligible employer-sponsored plan is determined newly eligible for advance payments of the premium tax credit based in part on a finding that such individual is ineligible for qualifying coverage in an eligible-employer sponsored plan in accordance with 26 CFR 1.36B-2(c)(3), including as a result of his or her employer discontinuing or changing available coverage within the next 60 days, provided that such individual is allowed to terminate existing coverage has 60 days before and after the loss of eligibility for qualifying coverage in an eligible employer-sponsored plan to select a Qualified Health Plan.
- A qualified individual or Dependent who gains access to an individual coverage HRA or is newly provided a qualified small employer health reimbursement arrangement (QSEHRA) has 60 days before the triggering event to select a Qualified Health Plan, unless the HRA or QSEHRA was not required to provide the notice setting forth its terms to such individual or enrollee at least 90 days before the beginning of the plan year, as specified in 45 CFR 146.123(c)(6), 26 CFR 54.9802-4(c)(6), and 29 CFR 2590.702-2(c)(6) or section 9831(d)(4) of the Internal Revenue Code, as applicable, in which case the qualified individual or Dependent has 60 days before or after the triggering event to select a Qualified Health Plan.
- A qualified individual or Dependent who becomes pregnant as confirmed by a Provider has 90 days from the date the Provider confirms the pregnancy to select a Qualified Health Plan.
- A qualified individual or Dependent who did not receive timely notice of triggering events can select a new plan within 60 days of the date that he or she knew, or reasonably should have known, of the occurrence of the triggering event.

- A qualified individual or Dependent who gains access to new Qualified Health Plans as a result of a permanent move and had minimum essential coverage for one or more days during the 60 days preceding the date of the permanent move has 60 days before or after the triggering event to select a Qualified Health Plan.
- A qualified individual or Dependent becomes newly eligible due to release from incarceration has 60 days before and 60 days after the triggering event to select a Qualified Health Plan.

Adding New Dependents

Policyholders may enroll Dependents only as determined by the Maryland Health Benefit Exchange.

The Policyholder must notify Maryland Health Benefit Exchange of a new Dependent to be added to this Policy. The effective date of the Dependent's coverage must follow Maryland Health Benefit Exchange rules. Additional Premium may also be required, and it will be calculated from the date determined by Maryland Health Benefit Exchange.

NOTE. Subject to a determination of Maryland Health Benefit Exchange, an eligible child, including a grandchild, born to or adopted by you, your spouse, or your domestic partner will be covered from the time of birth until the 31st day after its birth. The newborn child will be covered from the time of its birth for loss due to Injury and Sickness, including loss from complications of birth, premature birth, medically diagnosed congenital defect(s), and birth abnormalities. The newly adopted child is covered from the date of adoption for at least 31 days. “Date of adoption” means the earlier of a judicial decree of adoption, or the assumption of custody, pending adoption, of a prospective adoptive child by a prospective adoptive parent.

Subject to a determination of Maryland Health Benefit Exchange, an eligible child in your or your spouse’s custody as a result of a guardianship of more than 12 months duration granted by a court or testamentary appointment is covered automatically from the date of such appointment for at least 31 days.

Premiums

All Premiums are payable on a monthly basis, by the Policyholder. The first Premium is due and payable on the effective date of this Policy. Subsequent Premiums are due and payable no later than the first day of the month thereafter that this Policy is in effect.

We will also accept Premium payments from the following third parties:

- Ryan White HIV/AIDS Program under title XXVI of the *Public Health Service Act.*
- Indian tribes, tribal organizations or urban Indian organizations.
- Local, State and Federal Government programs, including grantees directed by government programs to make payments on their behalf consistent with the program's statutory authority.

Each Premium is to be paid by you, or a third party identified above, without contribution or reimbursement by or on behalf of any other third party including, but not limited to, any health care provider or any health care provider sponsored organization.

Premiums shall not be pro-rated based upon your effective date of coverage. A full month's Premium shall be charged for the entire month in which your coverage becomes effective.

Upon prior written notice, we may impose an administrative fee for credit card payments. This does not obligate us to accept credit card payments. We will charge a $20 fee for any check or automatic payment deduction that is returned unpaid.

Misstatement of Age

If your age has been misstated, Benefits may be adjusted based on the relationship of the Premium paid to the Premium that should have been paid, based on the correct age .

Change or Misstatement of Residence

If you change your residence, you must notify Maryland Health Benefit Exchange of your new residence. Your Premium will be based on your new residence beginning on the date determined by Maryland Health Benefit Exchange. If the change in residence results in the Policyholder no longer living in the Service Area, this Policy will terminate as described in *Section 4: When Coverage Ends*.

Grace Period

A grace period of 31 days shall be granted for the payment of any Premium, during which time coverage under this Policy shall continue in force. If payment is not received within this 31-day grace period, coverage may be canceled after the 31st day and the Policyholder shall be held liable for the cost of services received during the grace period. In no event shall the grace period extend beyond the date this Policy terminates.

We may pay Benefits for Covered Health Care Services incurred during this 31-day grace period. Any such Benefit payment is made in reliance on the receipt of the full Premium due from you by the end of the grace period.

If you are receiving an *Advance Payment of Tax Credit*, as allowed under *section 36B of title 26*, as provided for by the *Patient Protection and Affordable Care Act (PPACA),* you will have a three-month grace period during which you may pay your Premium and keep your coverage in force. We will pay for Covered Health Care Services during the first month of the grace period. You are responsible for paying the grace period Premium. Prior to the last day of the three-month grace period, we must receive all Premiums due for those three months. No claims will be paid beyond the first month of the grace period until all Premiums are paid for the full three-month grace period.

Adjustments to Premiums

We reserve the right to change the schedule of Premiums on January 1st of each calendar year. We shall give written notice of any change in Premium to the Policyholder at least 45 days prior to the effective date of the change.

Section 4: When Coverage Ends

General Information about When Coverage Ends

As permitted by law, we may end this Policy and/or all similar policies for the reasons explained in this Policy.

Your right to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date, except as noted below under *Extended Coverage Related to a Claim*. For extended Benefits for pediatric dental and vision services, please see *Section 11: Pediatric Dental Care Services* and *Section 12: Pediatric Vision Care Services*.

When your coverage ends, we will still pay claims for Covered Health Care Services that you received before the date your coverage ended. However, once your coverage ends, we will not pay claims for any health care services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended).

Unless otherwise stated, an Enrolled Dependent's coverage ends on the date the Policyholder's coverage ends.

We will refund any Premium paid and not earned due to Policy termination.

This Policy may also terminate due to changes in the actuarial value requirements under state or federal law. If this Policy terminates for this reason, a new Policy, if available, may be issued to you.

You may keep coverage in force by timely payment of the required Premiums under this Policy or under any subsequent coverage you have with us.

This Policy will renew on January 1 of each calendar year. However, we may refuse renewal if any of the following occur:

- We refuse to renew all policies issued on this form, with the same type and level of Benefits, to residents of the state where you then live, as explained under *The Entire Policy Ends* below.
- There is fraud or intentional misrepresentation made by you or with your knowledge in filing a claim for Benefits, as explained under *Fraud or Intentional Misrepresentation* below.
- Your eligibility would otherwise be prohibited under applicable law.

What Events End Your Coverage?

Coverage ends on the earliest of the dates specified below. When any of the following happen, we will provide written notice including the termination date and the reason for termination to the Policyholder:

- **The Entire Policy Ends**

  Your coverage ends on the date this Policy ends. That date will be one of the following:

  - The date determined by the Maryland Health Benefit Exchange that this Policy will terminate because the Policyholder no longer lives in the Service Area.
  - The date we specify, after we give you 90 days prior written notice, that we will terminate this Policy because we will discontinue offering and refuse to renew all policies issued on this form, with the same type and level of benefits, for all residents of the state where you reside. You will be offered an option to purchase any other coverage in the individual market we offer in your state at the time of discontinuance of this Policy. This option to purchase other coverage will be on a guaranteed issue basis without regard to health status.
  - The date we specify, after we give you and the applicable state authority at least 180 days prior written notice, that we will terminate this Policy because we will discontinue offering and refuse to renew all individual policies/certificates in the individual market in the state where you reside.

- **You Are No Longer Eligible**

Your coverage ends on the date you are no longer eligible to be a Policyholder or an Enrolled Dependent, as determined by the Maryland Health Benefit Exchange, unless you request an earlier termination date. Please refer to *Section 8: Defined Terms* for definitions of the terms “Eligible Person,” “Policyholder,” "Dependent" and "Enrolled Dependent." If the Maryland Health Benefit Exchange determines you are no longer eligible for coverage through the exchange, you may continue coverage with us outside of the exchange.

- **We Receive Notice to End Coverage**

Your coverage ends on the date determined by the Maryland Health Benefit Exchange rules if we receive notice from the Maryland Health Benefit Exchange instructing us to end your coverage.

Your coverage ends on the date determined by the Maryland Health Benefit Exchange rules if we receive notice from you instructing us to end your coverage. The Maryland Health Benefit Exchange must permit a Covered Person to terminate his or her coverage under the Policy, including as a result of the Covered Person obtaining other minimum essential health coverage, with reasonable notice to the Maryland Health Benefit Exchange. Reasonable notice is defined as fourteen days from the requested effective date of termination. Effective date for such termination is: 1) the date specified by the Covered Person if reasonable notice was provided as described above; or 2) fourteen days after termination is requested by the Covered Person when appropriate notice is not provided; or 3) the date on which the termination is requested by the Covered Person, or on another prospective date selected by the Covered Person; or 4) the date on or after the date the termination is requested by the Covered Person that is less than fourteen days after the termination is requested by the Covered Person, if the Covered Person requests an earlier termination date; or 5) if the Covered Person is newly eligible for Medicaid, CHIP, or the BHP, if a BHP is operating in the service area of the Maryland Health Benefit Exchange, the last day of coverage is the day before the individual is determined eligible for Medicaid, CHIP, or the BHP.

The Maryland Health Benefit Exchange must permit a Covered Person to retroactively terminate or cancel his or her coverage in the following circumstances when the request for termination or cancellation is made within 60 days of the event: 1) the Covered Person demonstrates to the Maryland Health Benefit Exchange that he or she attempted to terminate his or her coverage or enrollment in a Qualified Health Plan and experienced a technical error that did not allow termination of coverage or enrollment through the Maryland Health Benefit Exchange; 2) the Covered Person demonstrates to the Maryland Health Benefit Exchange that his or her enrollment in a Qualified Health Plan through the Maryland Health Benefit Exchange was unintentional, inadvertent, or erroneous and was the result of the error or misconduct of an officer, employee, or agent of the Maryland Health Benefit Exchange or HHS, its instrumentalities, or a non-Exchange entity providing enrollment assistance or conducting enrollment activities; or 3) the Covered Person demonstrates to the Maryland Health Benefit Exchange that he or she was enrolled in a Qualified Health Plan without his or her knowledge or consent by any third party, including third parties who have no connection with the Maryland Health Benefit Exchange. The termination date for a retroactive termination based on the circumstances described in item 1) within this paragraph will be based on the date the Covered Person can demonstrate he or she contacted the Maryland Health Benefit Exchange to terminate coverage or enrollment through the Maryland Health Benefit Exchange, had the technical error not occurred. The cancellation or termination date for a retroactive cancellation or termination will be the original effective date or a later date as determined by the Maryland Health Benefit Exchange, based on the circumstances of the cancellation or termination for 2) and 3) within this paragraph.

The Maryland Health Benefit Exchange may cancel the Covered Person's enrollment upon its determination that the enrollment was performed without the Covered Person's knowledge or consent and following reasonable notice to the Covered Person, where possible. The termination date will be the original coverage effective date.

If a Covered Person changes from one Qualified Health Plan to another Qualified Health Plan during the annual open enrollment period or a special enrollment period, the Maryland Health Benefit Exchange will terminate coverage. The last day of coverage in a Covered Person's prior Qualified Health Plan is the day before the effective date of coverage in his or her new Qualified Health Plan, including any retroactive enrollments effectuated under 155.420(b)(2)(iii).

Other Events Ending Your Coverage

When any of the following happen, we will provide written notice including the termination date and the reason for termination to the Policyholder:

- **Failure to Pay**

  You fail to pay the required Premium. The termination effective date will be the last day of the 31-day grace period, or for recipients of advance payments of the premium tax credit, the last day of the first month of the 3-month grace period.

- **Policyholder's Death**

  The Policyholder dies. The termination effective date will be the date of the Policyholder's death.

- **Fraud or Intentional Misrepresentation of a Material Fact**

  We will provide at least 30 days advance required notice to the Policyholder that coverage will end on the date we identify in the notice because you committed an act, practice, or omission that constituted fraud, or an

intentional misrepresentation of a material fact. Examples include knowingly providing incorrect information relating to another person's eligibility or status as a Dependent. You may appeal this decision during the notice period. The notice will contain information on how to appeal the decision.

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

Your coverage will be voided/rescinded and claims will be denied if you perform an act or practice that constitutes fraud. We will demonstrate, if required, to the reasonable satisfaction of the Maryland Health Benefit Exchange that rescission is appropriate.

- **You Accept Reimbursement for Premium**
- You accept any direct or indirect contribution or reimbursement by or on behalf of any third party including, but not limited to, any health care provider or any health care provider sponsored organization for any portion of the Premium for coverage under this Policy. This prohibition does not apply to the following third parties:
  - *Ryan White HIV/AIDS Program* under *title XXVI of the Public Health Service Act.*
  - Indian tribes, tribal organizations or urban Indian organizations.
  - Local, State and Federal Government programs, including grantees directed by government programs to make payments on their behalf consistent with the program's statutory authority.
- **The Plan is Decertified**

  This plan is decertified as a Qualified Health Plan by the Maryland Health Benefit Exchange. If the plan is decertified, coverage will be continued outside of the Maryland Health Benefit Exchange.

Coverage for a Disabled Dependent Child

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

- The Enrolled Dependent child is not able to support him/herself because of mental, developmental, or physical incapacity that originated before the Enrolled Dependent child attained the limiting age.
- The Enrolled Dependent child is chiefly dependent on the Policyholder or Enrolled Dependent for support.

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

You must furnish us with proof of the medical certification of incapacity within 31 days after the child reaches the terminal age. Before we agree to this extension of coverage for the child, we may require that a Physician we choose examine the child. We will pay for that exam.

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

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

Extended Coverage Related to a Claim

When a Covered Person has a claim in process on the date that coverage terminates, a temporary extension of coverage will be granted for Covered Health Service related to the claim.

The temporary extension will continue until:

- The Covered Person is released from the care of Physician for a condition that is the basis of the claim; or
- 12 months from the date of coverage under the Policy would otherwise have terminated whichever occurs first.

Reinstatement

When coverage under this Policy terminates for any reason, we will not reinstate coverage. You must make application for coverage under another Policy, subject to the rules of the Maryland Health Benefit Exchange.

Section 5: How to File a Claim

How Are Covered Health Care Services from Network Providers Paid?

We pay Network Providers directly for your Covered Health Care Services. If a Network Provider bills you for any Covered Health Care Service, contact us. However, you are required to meet any applicable deductible and to pay any required Co-payments and Co-insurance to a Network Provider.

How Are Covered Health Care Services from an Out-of-Network Provider Paid?

When you receive Covered Health Care Services from an Out-of-Network Provider as a result of an Emergency, at an Urgent Care Center outside your geographic are, or if a Covered Health Care Service received by an Out-of-Network Provider was preauthorized or otherwise approved by us or Network Provider, or obtained pursuant to a verbal or written referral by us or a Network Provider, we will pay Out-of-Network Providers directly. However, if you have already paid the Out-of-Network Provider, we will accept a request for payment submitted by you. If you submit a request for payment, we do not require that you complete a claim form, however you must file the claim in a format that contains all of the information we require, as described below.

Notice of Claim

You have up to a year from the date of service to submit a request for payment of Benefits. Failure to furnish the request for payment within the time required does not invalidate or reduce a claim if it was not reasonably possible to submit the request within the required time and the claim is submitted within two years after the date of service. If you are legally incapacitated, the time frame for submitting a claim is suspended until legal capacity has been regained. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Claim Forms and Proof of Loss

We do not require that you complete and submit a claim form. Instead, you can provide proof of loss by furnishing us with all of the information listed directly below under Required Information.

Required Information

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

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

The above information should be filed with us at the address on your ID card or contact us at the telephone number on your ID card for other options for submitting claims.

When filing a claim for Outpatient Prescription Drug Benefits, your claims should be submitted to:

OptumRx Claims Department

PO Box 650540

Dallas, TX 75265-0540

Fax number (non-urgent correspondence): (801) 994-1224

Fax number (urgent appeals): (801) 994-1261

Fax number (non-urgent appeals): (801) 994-1082

Payment of Claims

Time for Payment of Claim

Benefits will be paid within 30 days from the date we receive written notice of all of the required information listed above.

Assignment of Benefits

Providers have 180 days to file a claim. We will pay Benefits within 30 days after we receive the request for payment that includes all required information.

You do not have the right to bring any legal proceeding or action against us within 60 days of the date you submit your request for payment as directed above or after the expiration of 3 years after written proof of loss is required to be furnished.

- In addition, if a child has coverage through an insuring parent, we will pay Benefits to the non-insuring parent, health care provider, or the Maryland Department of Health if the non-insuring parent incurs expenses for the health care provided to the child.

You may not assign your Benefits under this Policy or any cause of action related to your Benefits under this Policy to an Out-of-Network Provider without our consent. When an assignment is not obtained, we will send the reimbursement directly to the Policyholder for reimbursement to an Out-of-Network Provider. We may, as we determine, pay an Out-of-Network Provider directly for services rendered to you. In the case of any such assignment of Benefits or payment to an Out-of-Network Provider, we have the right to offset Benefits to be paid to the provider by any amounts that the provider owes us.

When you assign your Benefits under this Policy to an Out-of-Network Provider with our consent, and the Out-of-Network Provider submits a claim for payment, you and the Out-of-Network Provider represent and warrant the following:

- The Covered Health Care Services were actually provided.
- The Covered Health Care Services were medically appropriate.
- Allowed Amounts due to an Out-of-Network Provider for Covered Health Care Services that are subject to the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260)* are paid directly to the provider.

Payment of Benefits under the Policy shall be in cash or cash equivalents, or in a form of other consideration that we determine to be adequate. Where Benefits are payable directly to a provider, such adequate consideration includes the forgiveness in whole or in part of the amount the provider owes us, or to other plans for which we make payments where we have taken an assignment of the other plans' recovery rights for value.

Section 6: Questions, Complaints and Appeals

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

What if You Have a Question?

Our Customer Service Representatives are trained to answer your questions about your health benefit plan. You may call or write to us. Call the telephone number shown on your ID card.

You may call during local business hours, Monday through Friday, with questions regarding:

- Your coverage and Benefit levels, including Co-insurance and Co-payment amounts.
- Specific claims or services you have received.
- Doctors or Hospitals in the Network.
- Referral processes or authorizations.
- Provider directories.

You may also complete a Member Services Request Form from myuhc.com and mail to the address included in the instructions.

What if You Have a Complaint?

A complaint is an expression of dissatisfaction.

You may call or write to us to file a complaint about quality of service and quality of care that you received. Call the telephone number shown on your ID card. Representatives are available to take your call during local business hours, Monday through Friday.

You may write a letter or complete a Member Services Request Form from myuhc.com. To send your complaint to us, our address is:

UnitedHealthcare Appeals & Grievances

PO Box 6111

Mail Stop CA-0197

Cypress, CA 90630

We will notify you of our decision regarding your complaint within 60 calendar days of receiving it.

If someone other than yourself is submitting the complaint on your behalf, you must authorize the representative in writing.

What Do the Terms in This Section Mean?

For the purposes of this Section, the following terms have the following meanings:

- “Adverse decision” is our utilization review determination that a proposed or delivered Covered Health Care Service which would otherwise be covered under the Policy is not or was not Medically Necessary, appropriate or efficient, and may result in non-coverage of the health service. It does not include a decision concerning a subscriber’s status as a member.
- “Compelling reason” means to show that a potential delay in receipt of a health care service until after the Covered Person or health care provider exhausts the internal grievance process and obtains a final decision under the grievance process could result in loss of life, serious impairment to a bodily function, serious dysfunction of a bodily organ, the Covered Person remaining seriously mentally ill or using intoxicating substances with symptoms that cause the Covered Person to be in danger to self or others or the Covered Person continuing to experience severe withdrawal symptoms. A Covered Person is considered to be in danger to self or others if the Covered Person is unable to function in activities of daily living or care for self without imminent dangerous consequences.
- “Complaint” is a protest filed with the Insurance Commissioner involving an adverse decision or grievance decision concerning a Covered Person.

- “Grievance” means a protest by you, your representative, or your health care provider on your behalf with us through our internal grievance process regarding an adverse decision.
- “Grievance decision” is a final determination by us that arises from a grievance filed with us under our internal grievance process regarding an adverse decision.
- “Health Advocacy Unit” means the Health Education and Advocacy Unit in the Division of Consumer Protection of the Office of the Attorney General.
- “Health care provider” means a Hospital, or an individual who is licensed or otherwise authorized in the State of Maryland to provide health care services in the ordinary course of working or practice of a profession and is a treating provider of a Covered Person.
- “Your representative” means an individual who has been authorized by you to file a grievance or a complaint on your behalf.

Notice Requirements

All notification requirements provided to you, your representative, and/or your health care provider as described in this Section will be provided in a culturally and linguistically appropriate manner.

Complaints

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

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

Internal Grievance Process

Under the law, you must exhaust our internal grievance process before you, your representative, or your health care provider file a complaint with the Insurance Commissioner, unless the adverse decision involves an emergency case for which services have not already been rendered, or is described above under Complaints, or unless it is under one of the other circumstances outlined below. For retrospective denials (denials on health services which have already been rendered), a compelling reason may not be shown. If the adverse decision by us involves a compelling reason for which services have not been rendered, you, your representative, or your health care provider may address your complaint directly to the Insurance Commissioner without first directing it to us.

Adverse Decisions

We will not make an adverse decision retrospectively regarding preauthorized or approved Covered Health Care Services delivered to a Covered Person, unless such preauthorization or approval was based on fraudulent, intentionally misrepresented, or omitted information. Such omitted information must have been critical requested information regarding the Covered Health Care Services whereby the preauthorization or approval for such Covered Health Care Services would not have been approved if the requested information had been received.

For non-emergency cases, if we render an adverse decision, a notice of this adverse decision will be communicated to you, your representative, or your health care provider either:

- Orally by telephone; or
- With your, your representative or your health care provider’s consent, by text, facsimile, e-mail, online portal, or other expedited means.

We will document the adverse decision in writing after we have provided the verbal communication of the adverse decision as described above.

Written notification of the adverse decision will be sent to you, your representative, and your health care provider within five working days after the adverse decision has been made.

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

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

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

Grievance Decision

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

- The adverse decision grievance must be filed by you, your representative, or your health care provider on your behalf, with us within 180 calendar days of receipt of our adverse decision.
- For prospective denials (denials on health services that have not yet been rendered), we will render a grievance decision in writing within 30 calendar days after the filing date, unless it involves an emergency case as explained below. The "filing date" is the earlier of five days after the date the grievance was mailed or the date of receipt. Unless written permission has been given, you, your representative, or your health care provider on your behalf, have the right to file a complaint with the Insurance Commissioner, if you have not received our grievance decision on or before the 30th calendar day after the filing date.
- For retrospective denials (denials on health services that have already been rendered), we will render a grievance decision within 45 calendar days after the filing date. Unless written permission has been given, you, your representative, or your health care provider on your behalf, have the right to file a complaint with the Insurance Commissioner (see below), if you have not received our grievance decision on or before the 45th calendar day after the filing date.
- With written permission from you, your representative, or your health care provider on your behalf, the time frame within which we must respond can be extended up to an additional 30 business days.
- If we need additional information in order to review the case, we will notify you, your representative and/or your health care provider within five business days after the filing date. We will assist you, your representative, or the health care provider in gathering the necessary medical records without further delay. If no additional information is available or is not submitted to us, we will render a decision based on the available information.
- Except as described under the first two bullets in the Complaints provision above, for retrospective denials, you, your representative, or your health care provider on your behalf, must file a grievance with us before filing a complaint with the Insurance Commissioner, as described below.
- Notice of our grievance decision will be verbally communicated to you, your representative, or your health care provider. Written notification of our grievance decision will be sent to you, your representative and any health care provider who filed a grievance on your behalf within five business days after the grievance decision has been made. If we uphold the adverse determination, the denial notification will include a Notice of Grievance Decision. This Notice will include the appropriate information in the bulleted items under Adverse Decision above. This notice will also include a statement that the Health Advocacy Unit is available to assist you or your representative in filing a complaint with the Insurance Commissioner.

- If any new or additional evidence is relied upon or generated by us during the determination of the grievance, we will provide it to you free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.
- In addition to the first two bullets of the Complaints provision above, for prospective denials, you, your representative, or your health care provider on your behalf, may file an complaint with the Insurance Commissioner (see below) without first filing an grievance with us, if you, your representative, or your health care provider can demonstrate that the adverse decision concerns a compelling reason for which a delay would result in loss of life, serious impairment to a bodily function, serious dysfunction of a bodily organ, the Covered Person remaining seriously mentally ill or using intoxicating substances with symptoms that cause the Covered Person to be in danger to self or others or the Covered Person continues to experience severe withdrawal symptoms.

Expedited Review in Emergency Cases

In emergency cases, you, your representative or your health care provider on your behalf may request an expedited review of an adverse decision. An “emergency case” is a case involving an adverse decision of proposed health services which are necessary to treat a condition or illness that, without immediate medical attention, would seriously jeopardize the life or health of the Covered Person or his or her ability to regain maximum function, or would cause the Covered Person to be in danger to self or others, or cause the Covered Person to continue using intoxicating substances in an imminently dangerous manner.

The procedure listed below will be followed:

- If the health care provider filed the grievance, he or she will determine whether the basis for an emergency case or expedited review exists. If the Covered Person, or the Covered Person’s representative, filed the grievance, we, in consultation with the health care provider, will determine whether the basis for an emergency case or expedited review exists. In either case, the determination will be based on the above definition of “emergency case”.
- We will render a verbal grievance decision to a grievance filed by you, your representative, or your health care provider on your behalf, within 24 hours of receipt of the grievance. Within one day after the verbal grievance decision has been communicated, we will send notice in writing of any grievance to you, your representative, and if applicable, your health care provider. If we need additional information in order to review the case, we will verbally inform you, your representative and/or your health care provider, and will assist with procuring the additional information. If we do not render a grievance decision within 24 hours, you, your representative, or your health care provider may file a complaint directly with the Insurance Commissioner. If we uphold our decision to deny coverage for the Covered Health Care Services, we will send you, your representative and/or your health care provider the grievance decision in writing within one day of the verbal notification. The Notice of Grievance Decision will include the appropriate information specified for the Notice of Adverse Decision above and will include that the Health Advocacy Unit is available to assist you or your representative in filing a complaint with the Insurance Commissioner.

Assistance From the Health Education and Advocacy Unit

The Health Advocacy Unit is available to assist you or your representative with filing a grievance under our internal grievance process and assist you or your representative in mediating a resolution of our adverse decision.

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

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

Health Education and Advocacy Unit
Consumer Protection Division
Office of the Attorney General
200 St. Paul Place, 16th Floor
Baltimore, Maryland 21202

Telephone: (410) 528-1840 or (877) 261-8870 (toll free)

Fax number: (410) 576-6571

E-mail: heau@oag.state.md.us

Website: https://www.marylandattorneygeneral.gov/Pages/CPD/HEAU

Medical Directors

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

Optimum Choice, Inc.
10175 Little Patuxent Parkway, 6th Floor
Columbia, Maryland 21044

(800) 691-0021

Complaints to the Insurance Commissioner

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

Maryland Insurance Administration
Attn: Consumer Complaint Investigation
Life and Health/Appeals & Grievance
200 St. Paul Place, Suite 2700
Baltimore, Maryland 21202

Telephone: (800) 492-6116 or (410) 468-2000 or TTY: (800) 735-2258

Fax Number: (410) 468-2270

Online: agcomplaints.mia@maryland.gov

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

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

Health Education and Advocacy Unit
200 St. Paul Place, 16th Floor
Baltimore, Maryland 21202

Telephone number: (410) 528-1840

Fax number: (410) 576-6571

E-mail: heau@oag.state.md.us

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

- For an emergency case, written notice of the Insurance Commissioner's final decision will be sent to the Covered Person, the Covered Person's representative and/or the health care provider within 24 hours after the Insurance Commissioner has given verbal notification of the final decision.
- For a complaint involving a pending health service, the Insurance Commissioner's final decision will be made within 45 calendar days after the complaint is filed.
- For a complaint involving a retrospective denial of health services already provided, the Insurance Commissioner's final decision will be made within 45 calendar days after the complaint is filed.

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

Assistance from State Agencies

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

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

Maryland Insurance Administration
Consumer Complaint & Investigation Life and Health/Appeals & Grievance
200 St. Paul Place, Suite 2700
Baltimore, Maryland 21202

Telephone number: (800) 492-6116 or (410) 468-2000 or TTY: (800) 735-2258

Fax number: (410) 468-2270 or (410) 468-2260

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

Office of the Attorney General Health Education and Advocacy Unit
200 St. Paul Place, 16th Floor
Baltimore, Maryland 21202
Telephone number: (410) 528-1840 or (877) 261-8807

Fax number: (410) 576-6571

E-mail: heau@oag.state.md.us

Coverage and Appeal Decisions

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

- "Appeal" means a protest filed by a Covered Person, a Covered Person's representative or a health care provider with us under our internal appeal process regarding a coverage decision concerning a Covered Person.
- "Appeal decision" means a final determination made by us that arises from an appeal filed with us under our appeal process regarding a coverage decision concerning a Covered Person.
- "Coverage decision" means:
  - An initial determination by us or our representative that results in non-coverage of a health care service;
  - A determination by us that an individual is not eligible for coverage under the Policy;
  - Any determination by us that results in the rescission of an individual's coverage under the Policy.
  - A coverage decision includes a nonpayment of all or any part of a claim.
  - A coverage decision does not include:
    - An adverse decision as described above; or
    - A pharmacy inquiry.
- "Health Advocacy Unit" means the Health Education and Advocacy Unit in the Division of Consumer Protection of the Office of the Attorney General.
- "Pharmacy inquiry" means an inquiry submitted by a pharmacist or pharmacy on behalf of a Covered Person to us or a pharmacy benefits manager at the point of sale about the scope of pharmacy coverage, pharmacy benefit design, or formulary, if available, under the Policy.
- "Your representative" means an individual who has been authorized by you to file an appeal or a complaint on your behalf.

If a coverage decision results in non-coverage of a health care service including non-payment of all or any part of your claim, you, your representative, or your health care provider acting on your behalf, have a right to file an appeal within one hundred eighty (180) calendar days of receipt of the coverage decision. The appeal may be submitted verbally or in writing and should include any information you, your representative or a health care provider acting on your behalf believe will help us review your appeal. You, your representative or a health care provider acting on your behalf may call the phone number listed on your identification card to verbally submit your appeal. Send the written appeal to:

UnitedHealthcare Appeals & Grievance
PO Box 6111
Mail Stop CA-0197
Cypress, CA 90630

We will render a final decision in writing within 60 calendar days after the date on which the appeal is filed. We will send you, your representative and your health care provider acting on your behalf, a written notice, within 30 days, of the appeal decision. If upheld, the notice of an appeal decision will include the following:

- Details concerning the specific factual basis for the decision in clear, understandable language;
- The right for you, your representative, or a health care provider acting on your behalf, to file a complaint with the Insurance Commissioner within four months of receipt of our appeal decision;
- The Insurance Commissioner's address, telephone number and fax number;
- A statement that the Health Advocacy Unit is available to assist you in filing a complaint with the Insurance Commissioner; and
- The information shown below regarding assistance from the Health Advocacy Unit.

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

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

Assistance from the Health Education and Advocacy Unit

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

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

You or your representative may contact the Health Advocacy Unit at:

Office of the Attorney General Health Education and Advocacy Unit
200 St. Paul Place, 16th Floor
Baltimore, Maryland 21202

Telephone numbers: (410) 528-1840 or toll free at (877) 261-8807

Fax number: (410) 576-6571

E-mail: heau@oag.state.md.us

Website address: https://www.marylandattorneygeneral.gov/Pages/CPD/HEAU

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

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

- A medical condition, including a physical condition, a mental condition, or a dental condition, where the absence of medical attention within 72 hours could reasonably be expected by an individual, acting on our behalf, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, to result in:
    - Placing the Covered Person's life or health in serious jeopardy;
    - The inability of the Covered Person to regain maximum function;
    - Serious impairment to bodily function;
    - Serious dysfunction of any bodily organ or part; or

- The Covered Person remaining seriously mentally ill with symptoms that cause the Covered Person to be a danger to self or others; or
- A medical condition, including a physical condition, a mental health condition, or a dental condition, where the absence of medical attention within 72 hours in the opinion of a health care provider with knowledge of the Covered Person's medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the coverage decision.

Section 7: General Legal Provisions

What Is Your Relationship with Us?

It is important for you to understand our role with respect to this Policy and how it may affect you. We administer this Policy under which you are insured. We do not provide medical services or make treatment decisions. This means:

- We communicate to you decisions about whether the Policy will cover or pay for the health care that you may receive. The Policy pays for Covered Health Care Services, which are more fully described in this Policy.
- The Policy may not pay for all treatments you or your Physician may believe are needed. If the Policy does not pay, you will be responsible for the cost.

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

Please refer to our *Notice of Privacy Practices* for details.

What Is Our Relationship with Providers?

We have agreements in place that govern the relationship between us and Network Providers, some of which are affiliated providers. Network Providers enter into an agreement with us to provide Covered Health Care Services to Covered Persons.

We do not provide health care services or supplies, or practice medicine. We arrange for health care providers to participate in a Network and we pay Benefits. Network Providers are independent practitioners who run their own offices and facilities. Our credentialing process confirms public information about the providers' licenses and other credentials. It does not assure the quality of the services provided. We are not responsible for any act or omission of any provider.

What Is Your Relationship with Providers?

The relationship between you and any provider is that of provider and patient.

You are responsible for all of the following:

- Choosing your own provider.
- Paying, directly to your provider, any amount identified as a member responsibility, including Co-payments, Co-insurance, any deductible and any amount that exceeds the Allowed Amount, when applicable.
- Paying, directly to your provider, the cost of any non-Covered Health Care Service.
- Deciding if any provider treating you is right for you. This includes Network Providers you choose and providers that they refer.
- Deciding with your provider what care you should receive.

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

Do We Pay Incentives to Providers?

We pay Network Providers through various types of contractual arrangements. Some of these arrangements may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network Providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction and/or cost-effectiveness.
- Capitation - a group of Network Providers receives a monthly payment from us for each Covered Person who selects a Network Provider within the group to perform or coordinate certain health care services. The Network Providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

- Bundled payments - certain Network Providers receive a bundled payment for a group of Covered Health Care Services for a particular procedure or medical condition. Your Co-payment and/or Co-insurance will be calculated based on the provider type that received the bundled payment. The 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 Co-payment and/or Co-insurance may not be required if such follow-up services are included in the bundled payment. You may receive some Covered Health Care Services that are not considered part of the inclusive bundled payment and those Covered Health Care Services would be subject to the applicable Co-payment and/or Co-insurance as described in your *Schedule of Benefits*.

We use various payment methods to pay specific Network Providers. From time to time, the payment method may change. If you have questions about whether your Network Provider's contract with us includes any financial incentives, we encourage you to discuss those questions with your provider. You may also call us at the telephone number on your ID card. We can advise whether your Network Provider is paid by any financial incentive, including those listed above.

Are Incentives Available to You?

Incentive programs will be offered in combination with a non-UnitedHealthcare entity. We reserve the right to change the non-UnitedHealthcare entity administering the incentive program, however, in the event of a change, UnitedHealthcare will continue to offer the incentive program through an alternate entity. The decision about whether or not to take part in a program is yours alone. However, we recommend that you discuss taking part in such programs with your Physician. We will notify you of the opportunity to participate in available programs and of any criteria for eligibility. Contact us at www.myuhc.com/exchange or the telephone number on your ID card if you have any questions.

At no cost to you, the following incentive programs will be available under this Policy:

- Member Incentive Program
  - All Covered Person(s) ages 18 and older are eligible to redeem a $100 gift card for select retail participants by completing all of the following activities:
    - Opting into text messages from UnitedHealthcare;
    - Opting into paperless communications;
    - Enrolling in Auto Pay for plan premiums;
    - Completing a visit with a Primary Care Physician (PCP); and
    - Create an account on the myUHC.com member portal.
  - If you do not have the capability required to complete a qualifying activity, you will be permitted to earn the same incentive in a different way. If you would like additional information regarding this program, you may call us at the telephone number on your ID card.
- Clinical Quality Incentives
  - We will offer incentives for chronic condition management, such as diabetes, and for completing preventive care and screenings, consistent with evidence-based clinical guidelines. Eligible members can earn a $25 reward for completion of activities associated with each applicable clinical quality measure.
- Primary Care Physician Incentive
  - Eligible members ages 18 and older can redeem a $75 gift card by completing a Primary Care Physician visit within the calendar year.
- HouseCalls Incentive
  - Eligible members ages 18 and older can redeem a $50 gift card for select retail participants by completing an in-home or virtual health assessment with a HouseCalls advance practice clinician. The purpose of this program is to help close potential gaps in care to promote improved health outcomes and expand access to care for members who may benefit from an alternate path to care.
- Digital Fitness Class Program.
  - We will make a digital fitness program available to you in combination with a non-UnitedHealthcare entity. If we may change the entity administering this program, we will notify you. The purpose of this program is to

encourage you to take a more active role in managing your health and well-being. Participation in this program is voluntary. There are no financial incentives or benefits provided to you by this program.

- The program provides access to digital fitness content at no additional cost to you. Activities will include, but are not limited to cycling, treadmill, strength, yoga, meditation and/or other similar activities in the fitness app.
- To be eligible for this program, you must be a Covered Person who is 18 years or older as of your coverage effective or renewal date. We will notify you of the opportunity to enroll in the program. If you would like additional information regarding this program, you may call us at the telephone number on your ID card.

Incentive rewards for voluntary participation in these programs will not exceed a value of $500 or 30% of the total cost of coverage under this Policy.

Do We Receive Rebates and Other Payments?

We may receive rebates for certain drugs that are administered to you in your home or in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet any applicable deductible. As determined by us, we may pass a portion of these rebates on to you. When rebates are passed onto you, they may be taken into account in determining your Co-payment and/or Co-insurance.

Who Interprets Benefits and Other Provisions under the Policy?

We have the sole and exclusive authority to do all of the following:

- Interpret Benefits under this Policy.
- Interpret the other terms, conditions, limitations and exclusions set out in this Policy, including the *Schedule of Benefits* and any Riders and/or Amendments.
- Make factual determinations related to this Policy and its Benefits.

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

In certain circumstances, for purposes of overall cost savings or efficiency, we may offer Benefits for services that would otherwise not be Covered Health Care Services. The fact that we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.

Who Provides Administrative Services?

We provide administrative services or, as we determine, we may arrange for various persons or entities to provide administrative services, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time as we determine. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Amendments to this Policy

To the extent permitted by law, we have the right to change, interpret, withdraw or add Benefits or end this Policy.

Any provision of this Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which this Policy is delivered) is amended to conform to the minimum requirements of such statutes and regulations.

Uniform Modifications in Coverage

Changes and/or modifications in coverage that are consistent with state law and are effective uniformly among plans under this product may only be made upon the annual renewal date. Notice of renewal/uniform modifications of coverage will be provided to the Policyholder 60 days prior to the renewal date.

No other change may be made to this Policy unless it is made by an Amendment or Rider which has been signed by one of our officers and consistent with applicable notice requirements. All of the following conditions apply:

- Amendments and Riders, including Amendments due to uniform modifications in coverage as described above, to this Policy are effective upon renewal, except as otherwise permitted by law.
- No agent has the authority to change this Policy or to waive any of its provisions.

- No one has authority to make any oral changes or amendments to this Policy.

How Do We Use Information and Records?

We may use your individually identifiable health information as follows:

- To administer this Policy and pay claims.
- To identify procedures, products, or services that you may find valuable.
- As otherwise permitted or required by law.

We may request additional information from you to decide your claim for Benefits. We will keep this information confidential. We may also use de-identified data for commercial purposes, including research, as permitted by law. More detail about how we may use or disclose your information is found in our *Notice of Privacy Practices*.

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

We have the right to release records concerning health care services when any of the following apply:

- Needed to put in place and administer the terms of this Policy.
- Needed for medical review or quality assessment.
- Required by law or regulation.

During and after the term of this Policy, we and our related entities may use and transfer the information gathered under this Policy in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to our Notice of Privacy Practices.

For complete listings of your medical records or billing statements you may contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, we will designate other persons or entities to request records or information from or related to you, and to release those records as needed. Our designees have the same rights to this information as we have.

Do We Require Examination of Covered Persons?

In the event of a question or dispute regarding your right to Benefits, we may require that a Network Physician of our choice examine you at our expense.

Is Workers' Compensation Affected?

Benefits provided under this Policy do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Subrogation and Reimbursement

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. We shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type, for any actual payments made by us for services and benefits provided by us to any Covered Person as a result of the occurrence that gave rise to a cause of action in which the Covered Person has recovered for medical expenses from: (i) third parties, including any person alleged to have caused the Covered Person to suffer injuries or damages; (ii) the employer of the Covered Person or (iii) any person or entity obligated to provide benefits or payments to Covered Persons, including benefits or payments for underinsured or uninsured motorist protection (these third parties and persons or entities are collectively referred to as “Third Parties”); provided, however, that we will not seek to recover payments made to a Covered Person under a personal injury protection policy. The Covered Person agrees to assign to us all rights of recovery against Third Parties, to the extent of the actual payments made us for the services and benefits that we provided.

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

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

When Do We Receive Refunds of Overpayments?

If we pay Benefits for expenses incurred on your account, you, or any other person or organization that was paid, must make a refund to us if any of the following apply:

- All or some of the expenses were not paid or did not legally have to be paid by you. Such refund is not required if the Benefits were paid under Medicaid or for the treatment of tuberculosis, Mental Illness, or another illness covered under the Policy that is received in a Hospital or other institution of the state or of a county or municipal corporation of the state, whether or not the Hospital or other institution is deemed charitable.
- All or some of the payment we made exceeded the Benefits under this Policy.
- All or some of the payment was made in error.

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

If the refund is due from the Covered Person and the Covered Person does not promptly refund the full amount, we may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Benefits for the Covered Person that are payable under the Policy. If a person or organization other than the Covered Person has received an overpayment and thus owes a refund, we may pursue any and all legally available means to recover such overpayment. The recovery of an overpayment from a person or organization other than the Covered Person through those means shall not render the Covered Person responsible to make any additional refund to us or to a provider that the Covered Person did not otherwise owe.

The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

Is There a Limitation of Action?

You cannot bring any legal action against us to recover reimbursement until 60 days after you have properly submitted a request for reimbursement as described in *Section 5: How to File a Claim*. If you want to bring a legal action against us you must do so within three years of the date written proof of loss is required to be furnished or you lose any rights to bring such an action against us.

Liability for Reimbursement

If for any reason beyond our control we are unable to provide the Covered Health Care Services described in this Policy, we will reimburse any expenses you incur in obtaining the Covered Health Care Services through other providers, to the extent prescribed by the Insurance Commissioner of Maryland.

What Is the Entire Policy?

This Policy, the *Schedule of Benefits*, the Policyholder's *Application* and any Riders and/or Amendments, make up the entire Policy.

Contestability of the Policy

This Policy may not be contested, except for nonpayment of Premiums, after it has been in force for 2 years from its date of issue:

- Absent fraud, each statement made by an applicant or a Covered Person is considered to be a representation and not a warranty; and
- A statement made to effectuate coverage may not be used to avoid the coverage or reduce benefits under the Policy unless:
  - The statement is contained in a written instrument signed by the Covered Person, and
  - A copy of the statement is given to the Covered Person.

Section 8: Defined Terms

Air Ambulance - medical transport by rotary wing Air Ambulance or fixed wing Air Ambulance as defined in *42 CFR 414.605*.

Allowed Amounts - for Covered Health Care Services, incurred while the Policy is in effect, Allowed Amounts are determined by us or determined as required by law as shown in the *Schedule of Benefits*.

Allowed Amounts are determined in accordance with our reimbursement policy guidelines or as required by law. We develop these guidelines, as we determine, after review of all provider billings in accordance with one or more of the following methodologies:

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

Alternate Facility - a health care facility that is not a Hospital. It provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Care Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

It may also provide Mental Health Care Services or Substance-Related and Addictive Disorders Services on an outpatient or inpatient basis.

Amendment - any attached written description of added or changed provisions to the Policy. It is effective only when signed by us. It is subject to all conditions, limitations and exclusions of the Policy, except for those that are specifically amended.

Ancillary Services - items and services provided by out-of-Network Physicians or out-of-Network non-Physician practitioners at a Network Facility that are any of the following:

- Related to emergency medicine, anesthesiology, pathology, radiology and neonatology;
- Provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services; and
- Provided by an out-of-Network provider when no other Network provider is available.

Annual Deductible - the total of the Allowed Amount or the Recognized Amount when applicable, you must pay for Covered Health Care Services per year before we will begin paying for Benefits. It does not include any amount that exceeds Allowed Amounts or Recognized Amounts when applicable. The *Schedule of Benefits* will tell you if your plan is subject to payment of an Annual Deductible and how it applies.

Authorized Prescriber - has the meaning stated in *Section 12-101* of the *Health Occupation Article* of the Maryland Code.

Authorized Representative - an individual authorized under State law to provide consent on behalf of a patient, provided that the individual is not a provider affiliated with the facility or employee of the facility, unless such provider or employee is a family member of the patient.

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

Benefits - your right to payment for Covered Health Care Services that are available under this Policy.

Blood Product - includes, but is not limited to, Factor VII, Factor VIII, Factor IX, and cryoprecipitate.

Body Mass Index - a practical measure that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

Chemotherapy - charges incurred for the treatment of disease by chemical or biological antineoplastic agents or related supportive care regimens administered orally, intravenously or by injection. The chemical or biological antineoplastic agents or related supportive care regimens may be administered during a doctor's visit, home health care visit, or at an outpatient facility.

Co-insurance - the charge, stated as a percentage of the Allowed Amount or the Recognized Amount when applicable, that you are required to pay for certain Covered Health Care Services.

Congenital Anomaly - a physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.

Continuing Care Patient - an individual who, with respect to a provider or facility:

- Is undergoing a course of treatment for a serious and complex condition from the provider or facility;
- Is undergoing a course of institutional or inpatient care from the provider or facility;
- Is scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
- Is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
- Is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

Co-payment - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Care Services.

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

- The Co-payment.
- The Allowed Amount or the Recognized Amount when applicable.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function.

Covered Health Care Service(s) - health care services, including supplies, Prescription Drug Products or Pharmaceutical Products, which we determine to be all of the following:

- 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.
- Described as a Covered Health Care Service in this Policy under *Section 1: Covered Health Care Services, Section 10: Outpatient Prescription Drugs* and in the *Schedule of Benefits*.
- Not excluded in this Policy under *Section 2: Exclusions and Limitations* and *Section 10: Outpatient Prescription Drugs*, under *Outpatient Prescription Drugs Exclusions*.

Covered Person - the Policyholder or a Dependent, but this term applies only while the person is enrolled under this Policy. We use "you" and "your" in this Policy to refer to a Covered Person.

Covered Pharmaceutical Product - a Pharmaceutical Product and/or new dosage form that is classified as a *U.S. Food and Drug Administration (FDA)*-approved prescription medication or product administered in connection with a Covered Health Care Service by a Physician.

This does not include Pharmaceutical Product(s) 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.
- Which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) or another Pharmaceutical Product.
- 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 defined term, “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 monthly.

Custodial Care - services that are any of the following non-Skilled Care services:

- Non health-related services such as help with daily living activities. Examples include eating, dressing, bathing, transferring and ambulating.
- Health-related services that can safely and effectively be performed by trained non-medical personnel and are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function, as opposed to improving that function to an extent that might allow for a more independent existence.

Definitive Drug Test - quantitative test to identify specific medications, illicit substances and metabolites with numerical results reporting the specific quantities of a substance.

Dependent - the Policyholder's legal spouse or domestic partner or a child of the Policyholder or the Policyholder's spouse or domestic partner. The term "child" includes:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child placed in foster care.
- A grandchild who is unmarried and a dependent of the Policyholder or the Policyholder's spouse.
- A child, who is unmarried and a dependent of the Policyholder or the Policyholder's spouse, for whom legal custody or testamentary or court appointed guardianship other than temporary guardianship of less than 12 months duration has been awarded to the Policyholder or the Policyholder's spouse.
- A child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order.

The following conditions apply:

- A Dependent includes a child listed above under age 26.
- A child is no longer eligible as a Dependent on the last day of the year following the date the child reaches age 26 except as provided in *Section 4: When Coverage Ends* under *Coverage for a Disabled Dependent Child.*

The Policyholder must reimburse us for any Benefits paid during a time a child did not satisfy these conditions if the coverage of the child was provided due to an intentional misrepresentation of the child as an Eligible Dependent. During the first two years the Policy is in effect, we have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time the child was incorrectly covered under the Policy. Such Benefits payable to us will be reduced by the Premiums that were paid for the child's coverage during the time the child was incorrectly covered.

Designated Dispensing Entity - a pharmacy or other provider that has entered into an agreement with us, or with an organization contracting on our behalf, to provide Pharmaceutical Products for the treatment of specified diseases or conditions. Not all Network pharmacies or Network providers are Designated Dispensing Entities.

Designated Provider - a provider and/or facility that:

- Has entered into an agreement with us, or with an organization contracting on our behalf, to provide Covered Health Care Service for the treatment of specific diseases or conditions; or
- We have identified through our 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 Service Area. Not all Network Hospitals or Network Physicians are Designated Providers.

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

Designated Virtual Network Provider - a provider or facility that has entered into an agreement with us, or with an organization contracting on our behalf, to deliver Covered Health Care Services through live audio with video technology or audio only.

Dialysis - the process in which waste products are removed from the body by diffusion from one fluid compartment to another through a semi-permeable membrane. There are two types of renal dialysis procedures in common clinical usage: hemodialysis and peritoneal dialysis.

Domiciliary Care - Services that are provided to aged or disabled individuals in a protective, institutional or home-type environment. Services include shelter; housekeeping services, board, facilities and resources for daily living, and personal surveillance or direction in the activities of daily living.

Durable Medical Equipment (DME) - medical equipment

furnished by a supplier or a Home Health Agency that:

- Can withstand repeated use.
- Is primarily and customarily used to serve a medical purpose.
- Generally is not useful to an individual in the absence of a disability, Illness, or Injury; and
- Is appropriate for use in the home.

Eligible Person - a person who meets the eligibility requirements determined by the Maryland Health Benefit Exchange. An Eligible Person must live within the Service Area.

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

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

Emergency Facility - an emergency department of a Hospital, or an Independent Freestanding Emergency Department where Emergency Health Care Services are provided. Emergency Facility includes a Hospital, regardless of the department of the Hospital, in which items or services with respect to Emergency Health Care Services are provided by an Out-of-Network Provider or Out-of-Network Emergency Facility: after the individual is stabilized; and as part of outpatient observation or an inpatient or outpatient stay with respect to the Visit in which other Emergency Health Care Services are furnished.

Emergency Health Care Services - with respect to an Emergency:

- An appropriate medical screening examination (as required under section *1867 of the Social Security Act, 42 U.S.C. 1395dd*, or as would be required under such section if such section applied to an Independent Freestanding Emergency Department) that is within the capability of the emergency department of a Hospital, or an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency, and
- Within the capabilities of the staff and facilities available at the Hospital or an Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment, as are required under section *1867 of the Social Security Act (42 U.S.C. 1395dd),* or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, To Stabilize the patient (regardless of the department of the Hospital in which such further exam or treatment is furnished).
- Except as provided in the fourth bullet below, covered services that are furnished by an Out-of-Network Provider or Out-of-Network Emergency Facility after the individual is stabilized and as part of outpatient observation, or an Inpatient Stay or outpatient stay with respect to the Visit in which the services described in the first bullet above are furnished
- The covered services described in the third bullet item above are not included as Emergency Services if all of the following conditions are met:

    a) The attending Emergency Physician or Treating Provider determines that the individual is able to travel using nonmedical transportation or nonemergency medical transportation to an available Network

provider or facility located within a reasonable travel distance, taking into account the patient's medical condition.

b) The provider or facility furnishing such additional items and services satisfies the notice and consent criteria of *45 C.F.R § 149.420(c)* through *(g)* with respect to such items and services provided that the written notice additionally satisfies items 4.b.i. and ii. below, as applicable:

i. In the case of a Network Emergency Facility and an Out-of-Network Provider, the written notice must also include a list of any Network Providers at the facility who are able to furnish such items and services involved and notification that the participant, beneficiary, or Covered Person may be referred, at their option, to such a Network Provider.

ii. In the case of an Out-of-Network Emergency Facility, the written notice must include the good faith estimated amount that the individual m ay be charged for items or services furnished by the Out-of-Network Emergency Facility or by Out-of-Network Providers with respect to the Visit at such facility (including any item or service that is reasonably expected to be furnished by the Out-of-Network Emergency Facility or Out-of-Network Providers in conjunction with such items or services);

c) The individual (or an Authorized Representative of such individual) is in a condition to receive the information described in the second sub-bullet above, as determined by the attending emergency physician or Treating Provider using appropriate medical judgment, and to provide informed consent in accordance with applicable State law; and

d) The covered services are not rendered by a health care provider who is subject to § 19-710(p) of the Health-General Article.

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

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

1. Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified as appropriate for proposed use in any of the following, except for coverage of a drug for an off-label use of the drug if the drug is recognized for treatment in any of the standard reference compendia as recognized periodically by the federal Secretary of Health and Human Services or the Commissioner or in the standard medical literature, including, but not limited to:
   - *AHFS Drug Information (AHFS DI)* under therapeutic uses section;
   - *Elsevier Gold Standard's Clinical Pharmacology* under the indication section;
   - *DRUGDEX System by Micromedex* under the therapeutic uses section and has a strength recommendation rating of class I, class IIa, or class IIb; or
   - *National Comprehensive Cancer Network (NCCN)* drugs and biologics compendium category of evidence 1, 2A, or 2B.
2. 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 Experimental or Investigational.)
3. 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.
4. Only obtainable, with regard to outcomes for the given indication, within research settings.

Exceptions:

- Clinical trials for which Benefits are available as described under *Clinical Trials* in *Section 1: Covered Health Care Services*.
- We may, as we determine, consider an otherwise Experimental or Investigational Service to be a Covered Health Care Service for that Sickness or condition if:
  - You are not a participant in a qualifying clinical trial, as described under *Clinical Trials* in *Section 1: Covered Health Care Services*; and

- You have a Sickness or condition that is likely to cause death within one year of the request for treatment.

Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Freestanding Facility - an outpatient, diagnostic or ambulatory center or independent laboratory which performs services and submits claims separately from a Hospital.

Functional or Physical Impairment - a Functional or Physical or Physiological Impairment which causes deviation from the normal function of a tissue or organ. This results in a significantly limited, impaired, or delayed capacity to move, coordinate actions, or perform physical activities and is exhibited by difficulties in one or more of the following areas:

- physical and motor tasks;
- independent movement;
- performing basic life functions.

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 Care 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 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 Gestational Carrier does not provide the egg and is therefore not biologically related to the child.

Habilitative Services - Skilled Care services that are part of a prescribed treatment plan or Maintenance Program to help a person with a disability to keep, learn or improve skills and functioning for daily living. We will decide 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 disability are not considered habilitative services.

Habilitative services include:

- Physical therapy.
- Occupational therapy.
- Speech therapy.
- Post-cochlear implant aural therapy.
- Cognitive therapy.

Hearing Aid(s) - Hearing Aids are sound-amplifying devices designed to aid people who have a hearing impairment. Most Hearing Aids share several similar electronic components, and technology used for amplification may be analog or digital. (Semi-implantable electromagnetic Hearing Aids and bone-anchored Hearing Aids are classified by the *U.S. Food and Drug Administration (FDA)* as Hearing Aids. Some non-wearable hearing devices are described as hearing devices or hearing systems. Because their function is to bring sound more effectively into the ear of a person with hearing loss, for the purposes of this Policy, they are Hearing Aids).

Home Health Agency - a program or organization authorized by law to provide health care services for care or treatment of a Sickness or Injury in the home.

Home Health Care Services - services received from a Home Health Agency that are all of the following:

- 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.
- Provided on a part-time, Intermittent Care schedule.
- Provided when Skilled Care is required.
- Provides each patient with a planned program of observation and treatment by a Physician, in accordance with existing standards of medical practice for the Injury or Sickness requiring the Home Health Care.

Hospice Care - an integrated, structured, multi-disciplinary program of palliative care for covered members facing the last six months of life due to a Terminal Illness.

Hospice Program - a public agency or private organization that meets the requirements under *42 U.S.C. § 1395x(dd)2*, including but not limited to the following: (1) is primarily engaged in providing Hospice Care and makes such services available on a twenty-four (24) hour basis and which also provides bereavement counseling for the immediate family of terminally ill individuals; (2) provides for such care and service in individual's homes, on an outpatient basis, and on a short-term inpatient basis, directly or under arrangement made by the agency or organization, except that for required services not directly provided by the agency or organization, the agency or organization must maintain professional management responsibility for all such services regardless of the location of the facility where services are furnished; and for certain inpatient services as required under federal law, that the aggregate number of inpatient days meets such federal requirements; (3) has an interdisciplinary group of personnel which includes at least a Physician, registered professional nurse and social worker employed by or under contract with the agency or organization, and also includes at least one pastoral or other counselor, and provides (or supervises the provision of) the care and services and establishes the policies governing the provision of such care and services; (4) maintains central clinical records on all patients; (5) does not discontinue the Hospice Care it provides with respect to a patient because of the inability of the patient to pay for such care; (6) utilizes volunteers in its provision of care and maintains records on the use of these volunteers and the cost savings and expansion of care and services achieved through the use of these volunteers; (7) is licensed pursuant to Maryland law and (8) meets such other requirements as the Secretary may find necessary in the interest of the health and safety of the individuals who are provided care and services by such agency or organization.

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

- It is mainly engaged in providing inpatient health care services, for the short term care and treatment of injured or sick persons. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not mainly a place for rest, Custodial Care or care of the aged. It is not a nursing home, convalescent home or similar institution.

Hospital-based Facility - an outpatient facility that performs services and submits claims as part of a Hospital.

Independent Freestanding Emergency Department - a health care facility that:

- Is geographically separate and distinct and licensed separately from a Hospital under applicable state law; and
- Provides Emergency Health Care Services.

Infusion Therapy - means treatment by placing therapeutic agents into the vein and parenteral administration of medications and nutrients.

Injury - traumatic damage to the body, including all related conditions and symptoms.

Inpatient Rehabilitation Facility - any of the following that provides inpatient rehabilitation health care services (including physical therapy, occupational therapy and/or speech therapy), as authorized by law:

- A long term acute rehabilitation center,
- A Hospital, or
- A special unit of a Hospital designated as an Inpatient Rehabilitation Facility.

Inpatient Stay - a continuous stay that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Behavioral Therapy (IBT) - outpatient Mental Health Care 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. The most common IBT is *Applied Behavior Analysis (ABA)*.

Intensive Outpatient Treatment - a structured outpatient treatment program.

- For Mental Health Care Services, the program may be freestanding or Hospital-based or in a provider's office or other professional setting and provides services for at least three hours per day, two or more days per week.
- For Substance-Related and Addictive Disorders Services, the program provides nine to nineteen hours per week of structured programming for adults and six to nineteen hours for adolescents, consisting primarily of counseling and education about addiction related and mental health problems.

Intermittent Care - skilled nursing care that is provided either:

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

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

Long-term Acute Care Facility (LTAC) - means a facility or Hospital that provides care to people with complex medical needs requiring long-term Hospital stay in an acute or critical setting.

Maintenance Program - A program with the goals to maintain the functional status or to prevent decline in function.

Manipulative Treatment (adjustment)- a form of care provided by chiropractors and osteopaths for diagnosed muscle, nerve and joint problems. Body parts are moved either by hands or by a small instrument to:

- Restore or improve motion.
- Reduce pain.
- Increase function.

Medically Necessary - health care services, that are all of the following as determined by us or our designee.

- 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. We have 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 determined by us.

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

Mental Health/Substance-Related and Addictive Disorders Designee - the organization or individual, designated by us, that provides or arranges Mental Health Care Services and Substance-Related and Addictive Disorders Services.

Mental Illness - those mental health or psychiatric diagnostic categories 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 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 Care Service.

Morbid Obesity Surgery - procedures that are performed to treat comorbid conditions associated with morbid obesity.

Necessary Medical Supplies - medical supplies that are used in the home with covered DME are covered when the supply is necessary for the effective use of the item/device (e.g., batteries for power wheelchairs and prosthetics, or tubing for a delivery pump).

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with us or with our affiliate to participate in our Network. This does not include those providers who have agreed to discount their charges for Covered Health Care Services. Our affiliates are those entities affiliated with us through common ownership or control with us or with our ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Care Services, but not all Covered Health Care Services, or to be a Network Provider for only some of our products. In this case, the provider will be a Network Provider for the Covered Health Care Services and products included in the participation agreement and an Out-of-Network Provider for other Covered Health Care Services and products. The participation status of providers will change from time to time.

Network Area – the Service Area, supplemented by any additional providers we include as Network Area providers. Contact us at www.myuhc.com/exchange or the telephone number on your ID card for additional information on the Network Area.

Network Benefits - the description of how Benefits are paid for Covered Health Care Services provided by Network Providers. The *Schedule of Benefits* will tell you if your plan offers Network Benefits and how Network Benefits apply.

Network Emergency Facility - any Emergency Facility that has contracted directly with us or an entity contracting on behalf of us to provide health care services to our Covered Persons. A single case agreement between an Emergency Facility and us that is used to address unique situations in which a Covered Person requires services that typically occur out-of-network constitutes a contractual relationship for purposes of this definition, and is limited to the parties to the agreement.

Network Facility - a health care facility that has contracted directly with us or an entity contracting on behalf of us to provide health care services to our Covered Persons. A single case agreement between a health care facility and us that is used to address unique situations in which a Covered Person requires services that typically occur out-of-network constitutes a contractual relationship for purposes of this definition, and is limited to the parties to the agreement. Additionally, for purposes of this definition and in the context of non-emergency services, “health care facility” is limited to a hospital (as defined in section *1861(e) of the Social Security Act*); a hospital outpatient department; a critical access hospital (as defined in section *1861(mm)(1) of the Social Security Act*); and an ambulatory surgical center described in section *1833(i)(1)(A) of the Social Security Act*.

Network Provider - a Physician or Other Health Care Provider that has contracted directly with us or an entity contracting on behalf of us to provide health care services to our Covered Persons.

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 as determined by us or our designee, which is based on when the Pharmaceutical Product is reviewed and when utilization management strategies are implemented.
- December 31st of the following calendar year.

Ostomy Supplies - include pouches, face plates, belts, irrigation sleeves, bags, ostomy irrigated catheters, and skin barriers. Ostomy Supplies do not include deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed as included.

Other Health Care Provider - any person who is licensed or certified under applicable State law to provide health care services, and is acting within the scope of practice of that provider's license or certification, but does not include a provider of Air Ambulance Services.

Out-of-Network Benefits - the description of how Benefits are paid for Covered Health Care Services provided by Out-of-Network Providers. The Schedule of Benefits will tell you if your plan offers Out-of-Network Benefits and how Out-of-Network Benefits apply.

Out-of-Network Emergency Facility - an Emergency Facility that has not contracted directly with us or indirectly, such as through an entity contracting on behalf of us to provide health care services to our Covered Persons.

Out-of-Network Provider - a Physician or Other Health Care Provider that has not contracted directly with us or an entity contracting on behalf of us to provide health care services to our Covered Persons.

Out-of-Network Rate - with respect to an item or service furnished by an Out-of-Network Provider, Out-of-Network Emergency Facility, or Out-of-Network Provider of Air Ambulance Services:

- In a State that has an All-Payer Model Agreement under section *1115A of the Social Security Act* that applies to the plan/carrier, Out-of-Network Provider/Out-of-Network Emergency Facility, and item/service, the amount that the State approves under the All-Payer Model Agreement for the item or service. For certain items or services billed by Maryland hospitals, this is the amount for the item or service approved by the *Health Services Cost Review Commission (HSCRC)*.
- If there is no such All-Payer Model Agreement applicable to the item or service, but a specified State law is in effect and applicable, the amount for the item or service determined in accordance with such specified State law. Under specified Maryland law, this is the amount required by *§19-710.1 of the Health-General Article*.
- If there is no such All-Payer Model Agreement or specified State law applicable to the item or service, an amount agreed upon by us and the Out-of-Network Provider or Out-of-Network Emergency Facility.
- If none of the three conditions above apply, an amount determined by a certified independent dispute resolution (IDR) entity under the IDR process described in section *2799A-1(c) or 2799A-2(b) of the federal Public Health Service Act*, as applicable.

Out-of-Pocket Limit - the maximum amount you pay every year. The *Schedule of Benefits* will tell you how the Out-of-Pocket Limit applies.

Partial Hospitalization/Day Treatment/High Intensity Outpatient - a structured ambulatory program. The program may be freestanding or Hospital-based and provides services for at least 20 hours per week.

Patient Centered Medical Home - a Primary Care Practice organized to provide a first, coordinated, ongoing, and comprehensive source of care to patients to:

- Foster a partnership with a Covered Person;
- Coordinate health care services for a Covered Person; and
- Exchange medical information with carriers, other providers, and Covered Persons.

Personal Care - a service that an individual normally would perform personally, but for which the individual needs help from another because of advanced age, infirmity, or physical or mental limitation. Personal Care includes help with walking; getting in and out of bed; bathing; dressing; feeding and general supervision and help in daily living.

Pharmaceutical Product(s) - *U.S. Food and Drug Administration (FDA)*-approved prescription medications or products administered in connection with a Covered Health Care 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 or certification will be considered on the same basis as a Physician. It is important to verify

that both the Physician you seek services from is a Network Provider and the services provided are covered Benefits. Not all services provided by a Physician are covered by this Policy.

Policy - the entire agreement that includes all of the following:

- This Policy.
- *Schedule of Benefits*.
- Policyholder *Application*.
- Riders.
- Amendments.

These documents make up the entire agreement that is issued to the Policyholder.

Policyholder - the person (who is not a Dependent) to whom this Policy is issued.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

Premium - the periodic fee required for each Policyholder and each Enrolled Dependent, in accordance with the terms of this Policy.

Presumptive Drug Test - qualitative test to determine the presence or absence of drugs or a drug class with results indicating a negative or positive result.

Primary Care Practice - a practice or federally qualified health center organized by or including pediatricians, general internal medicine physicians, family medicine physicians, or nurse practitioners.

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

Private Duty Nursing - A provision of continuous Skilled Care from Registered Nurses (RNs) or Licensed Practical Nurses (LPNs) in an individual's residence by a Home Health Agency, under the direction of the patient's Physician.

Provider - A licensed participating provider who is contracted to provide medical services to Covered Persons (as defined within the provider contract). A Provider includes any individual or health care facility licensed or otherwise authorized under the *Health Occupations Article* to provide health care services. The provider may be a Hospital, pharmacy, other facility or a Physician or health care professional who has contractually accepted the terms and conditions as set forth.

Qualified Health Plan - a health plan that has a certification that it meets standards described in Federal law, which are issued or recognized by the Maryland Health Benefit Exchange.

Qualified Health Plan Issuer - a health insurance issuer that offers a Qualified Health Plan in accordance with a certification from Maryland Health Benefit Exchange.

Qualified Payment Amount - the amount calculated using the methodology described in *45 C.F. R. § 149.140(c)*, which is based on the median contracted rate for all plans offered by the carrier in the same insurance market for the same or similar item or service that is: provided by a provider in the same or similar specialty or facility of the same or similar facility type; and provided in the geographic region in which the item or service is furnished. The median contracted rate is subject to additional adjustments specified in federal regulations.

Recognized Amount - the amount which Co-payment, Co-Insurance and applicable deductible, is based on for the below Covered Health Care Services when provided by Out-of-Network Providers:

- Out-of-Network Emergency Health Care Services.
- Non-Emergency Covered Health Care Services received at certain Network facilities by out-of-Network Physicians, when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Service Ac*t. For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital

outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

The amount is based on one of the following in the order listed below as applicable:

1) An *All Payer Model Agreement* if adopted,

2) State law, or

3) The lesser of the Qualifying Payment Amount as determined under applicable law, or the amount billed by the provider or facility.

The Recognized Amount for Air Ambulance services provided by an Out-of-Network Provider will be calculated based on the lesser of the Qualifying Payment Amount as determined under applicable law or the amount billed by the Air Ambulance service provider.

Note: Covered Health Care Services that use the Recognized Amount to determine your cost sharing may be higher or lower than if cost sharing for these Covered Health Care Services were determined based upon an Allowed Amount.

Reconstructive Breast Surgery - surgery performed as a result of a mastectomy to reestablish symmetry between the two breasts, and includes augmentation mammoplasty, reduction mammoplasty, and masteopexy.

Reconstructive Surgery - procedures when the primary purpose of the procedure is either of the following:

- Treatment of a medical condition.
- Improvement or restoration of physiologic function.

Reconstructive procedures include surgery or other procedures which are related to an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance. Microtia repair is considered a reconstructive procedure.

Rehabilitation - health care services that help you keep, get back, or improve skills and functioning for daily living that have been lost or impaired because you were sick, hurt, or disabled.

Related Institution - an organized institution, environment, or home that: (1) maintains conditions or facilities and equipment to provide Domiciliary Care, Personal Care or nursing care for two or more unrelated individuals who are dependent on the administrator, operator or proprietor for nursing care or the subsistence of daily living in a safe, sanitary, and healthful environment; and (2) admits or retains the individual for overnight care.

Remote Physiologic Monitoring - the automatic collection and electronic transmission of patient physiologic data that are analyzed and used by a licensed physician or other qualified health care professional to develop and manage a plan of treatment related to a chronic and/or acute health illness or condition. The plan of treatment will provide milestones for which progress will be tracked by one or more Remote Physiologic Monitoring devices. Remote physiologic monitoring must be ordered by a licensed physician or other qualified health professional who has examined the patient and with whom the patient has an established, documented and ongoing relationship. Remote Physiologic Monitoring may not be used while the patient is inpatient at a Hospital or other facility. Use of multiple devices must be coordinated by one Physician.

Residential Crisis Services - intensive mental health and support services that are:

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

Residential Treatment - treatment in a facility established and operated as required by law, which provides Mental Health Care Services or Substance-Related and Addictive Disorders Services. It must meet all of the following requirements:

- Provides a program of treatment, under the active participation and direction of a Physician.

- Offers organized treatment services that feature a planned and structured regimen of care in a 24-hour setting and provides at least the following basic services:
    - Room and board.
    - Evaluation and diagnosis.
    - Medication provision/assistance.
    - Counseling.
    - Referral and orientation to specialized community resources.

A Residential Treatment facility that qualifies as a Hospital is considered a Hospital.

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

Secretary - as that term is applied in the *No Surprises Act* of the C*onsolidated Appropriations Act (P.L. 116-260)*.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Care Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is Medically Necessary, or when a Semi-private Room is not available.

Serious or Complex Condition - in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or in the case of a chronic illness or condition, a condition that is life-threatening, degenerative, potentially disabling, or congenital; and requires specialized medical care over a prolonged period of time.

Service Area - the geographic area where we act as a Qualified Health Plan Issuer as approved by the appropriate regulatory agency. Contact us to determine the exact geographic area we serve. The Service Area may change from time to time.

Short-Term Acute Care Facility - means a facility or Hospital that provides care to people with medical needs requiring short-term Hospital stay in an acute or critical setting such as for recovery following a surgery, care following sudden Sickness, Injury, or flare-up of a chronic Sickness.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this Policy 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, skilled habilitation and skilled rehabilitation services when all of the following are true:

- Must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- Ordered by a Physician.
- Not delivered for the purpose of helping with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- Requires clinical training in order to be delivered safely and effectively.

Not Custodial Care, which can safely and effectively be performed by trained non-medical personnel.

Skilled Nursing Facility - an institution, or a distinct part of an institution, licensed by the *Maryland Department of Health*, which is:

- Primarily engaged in providing:
    - Skilled nursing care and related services, for residents who require medical or nursing care, or
    - Rehabilitation services for the rehabilitation of the Injured, disabled or sick persons; and
- Certified by the Medicare Program as a skilled nursing facility.

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

Sub-Acute Facility - means a facility that provides intermediate care on short-term or long-term basis.

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 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 of the disorder is a Covered Health Care 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.

Telehealth/Telemedicine - interactive audio only conversations between a health care provider and a Covered Person that results in the delivery of a billable, Covered Health Care Service, video, or other telecommunications or electronic technology by a health care provider to deliver a Covered Health Care Service that is within the scope of practice of the health care provider at a location other than the location at which the patient is located regardless of the location of the patient at the time the Telehealth/Telemedicine services are provided. Telehealth/Telemedicine does not include audio-only telephone conversation (except as noted), facsimile, texting, instant message, electronic mail or virtual care services provided by a Designated Virtual Network Provider.

Temporomandibular Joint Syndrome (TMJ) - Temporomandibular joint and muscle disorders are a collective group of conditions and symptoms characterized by pain and dysfunction to the temporomandibular joint and/or surrounding muscles that control jaw movement. Symptoms often include pain or tenderness to the temporomandibular joint, ear, neck, back, or shoulder pain, limited jaw mobility, or audible sounds with jaw movement.

Terminal Illness - in the context of hospice means a life expectancy, certified by two Physicians, of six months or less.

To Stabilize - with respect to an Emergency, means to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

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

Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. They provide stable and safe housing, an alcohol/drug-free environment and support for recovery. They may be used as an addition to ambulatory treatment when it doesn't offer the intensity and structure needed to help you with recovery.

Supervised living arrangements which are residences such as facilities, group homes and supervised apartments. They provide stable and safe housing and the opportunity to learn how to manage activities of daily living. They may be used as an addition to treatment when it doesn't offer the intensity and structure needed to help you with recovery.

Treating Provider - a Physician or Other Health Care Provider who has evaluated the Covered Person.

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

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

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

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, as we determine, consider an otherwise Unproven Service to be a Covered Health Care Service for that Sickness or condition. Prior to such a consideration, we must first establish that

there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition.

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 Care Services that are required to prevent serious deterioration of your health. These services are required as a result of an unforeseen Sickness, Injury, or the onset of sudden or severe symptoms. Urgent Care facilities are a location, distinct from a hospital Emergency Department, an office or a clinic.

Visit - the instance of going to or staying at a health care facility, and, with respect to items and services furnished to an individual at a health care facility, includes, in addition to items and services furnished by a provider at the facility, equipment and devices, telemedicine services, imaging services, laboratory services, and preoperative and postoperative services, regardless of whether the provider furnishing such items or services is at the facility.

Section 9: Coordination of Benefits

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Policy will be coordinated with those of any other plan that provides benefits to you. The language in this section is from model laws drafted by the *National Association of Insurance Commissioners (NAIC)* and represents standard industry practice for coordinating benefits.

When 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; and Medicare or any other federal governmental plan, as permitted by law.

2. Plan does not include: hospital indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; intensive care policies; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; medical benefits under group or individual automobile contracts (fault and no-fault); or coverage under other federal governmental plans, unless permitted by law.

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

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

B. **This Plan.** 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.** Allowable Expense is a health care expense, including deductibles, co-insurance and co-payments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or according to contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense.

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

1. The difference between the cost of a semi-private hospital room and a private room is not an Allowable Expense unless one of the Plans provides coverage for private hospital room expenses.
2. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
3. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.
5. The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions and preferred provider arrangements.

E. **Closed Panel Plan.** 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.

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

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

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

1. **Non-Dependent or Dependent**. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Plan

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

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

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

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

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

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

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

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

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

      (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. To determine the length of time a person has been covered under a Plan, two successive Plans shall be treated as one if the Covered Person was eligible under the second plan within twenty-four (24) hours after coverage under the first plan ended. The state of a new Plan does not include:

   a) A change in the amount or scope of a Plan's benefits;

   b) A change in the entity that pays, provides, or administers the Plan's benefits; or

   c) A change from one type of plan to another, such as, from a single employer plan to a multiple employer plan.

   The person's length of time covered under a Plan is measured from the person's first date of coverage under that Plan. If that date is not readily available for a group plan, the date the person first become a member of the group shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.

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

Effect on the Benefits of This Plan

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

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

Right to Receive and Release Needed Information

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

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

Payments Made

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

Does This Plan Have the Right of Recovery?

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

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.

Section 10: Outpatient Prescription Drugs

This section of the Policy provides Network Benefits for Prescription Drug Products.

Because this section is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in either the Policy in *Section 8: Defined Terms* or in this section under the heading *Defined Terms for Outpatient Prescription Drugs.*

When we use the words "we," "us," and "our" in this document, we are referring to Optimum Choice, Inc. When we use the words "you" and "your" we are referring to people who are Covered Persons, as the term is defined in the Policy in *Section 8: Defined Terms*.

NOTE: The Coordination of Benefits provision in the Policy in *Section 9: Coordination of Benefits* applies to Prescription Drug Products covered through this section. Benefits for Prescription Drug Products will be coordinated with those of any other health plan in the same manner as Benefits for Covered Health Care Services described in this Policy.

Introduction

Coverage Policies and Guidelines

Our Individual and Family Plan Pharmacy Management Committee (IPMC) makes tier placement changes on our behalf. The IPMC places FDA-approved Prescription Drug Products into tiers by considering a number of factors including clinical and economic information. Clinical factors may include review of the place in therapy or use as compared to other similar product or services, site of care, relative safety or effectiveness of the Prescription Drug Product, as well as if certain supply limits or prior authorization requirements should apply. Economic factors may include the Prescription Drug Product's total cost including any rebates and evaluations of the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are more cost effective for treating specific conditions as compared to others; therefore, a Prescription Drug Product may be placed on multiple tiers according to the condition for which the Prescription Drug Product was prescribed to treat.

We may, from time to time, change the placement of a Prescription Drug Product among the tiers. These changes generally will happen up to monthly. These changes may happen without prior notice to you. In the event that a Prescription Drug Product that you are currently taking moves to a higher tier or is removed from the PDL, we will notify you no less than 30 days prior to the change. When that happens, you may pay more or less for a Prescription Drug Product, depending on its tier placement. Please contact us at www.myuhc.com/exchange or the telephone number on your ID card for the most up-to-date tier placement.

When considering a Prescription Drug Product for tier placement, the IPMC reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for you is a determination that is made by you and your prescribing health care practitioner.

NOTE: Tier status for a Prescription Drug Product may be determined by accessing your Benefits for Prescription Drug Products by contacting us at www.myuhc.com/exchange or the telephone number on your ID card. The tier to which a Prescription Drug Product is assigned may change as detailed in the Policy.

Prescription Drug Products that are considered to be PPACA Zero Cost Share Preventive Care Medications will be provided at $0 cost share for Covered Persons.

Identification Card (ID Card) - Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by us during regular business hours.

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you must pay the Usual and Customary Charge for the Prescription Drug Product at the pharmacy.

You can seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*. When you submit a claim on this basis, you may pay more because you did not verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Co-payment and/or Co-insurance, and any deductible that applies.

Submit your claim to:

OptumRx Claims Department

PO Box 650540

Dallas, TX 75265-0540

Designated Pharmacies

If you require certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products. If you choose not to obtain your Prescription Drug Product from the Designated Pharmacy, you may not have coverage.

When Do We Limit Selection of Pharmacies?

If we determine that you are using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your choice of Network Pharmacies can be limited. If this happens, we will require you to choose one Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the chosen Network Pharmacy. If you don't make a choice within 31 days of the date we notify you, we will choose a Network Pharmacy for you.

Coupons, Incentives and Other Communications

At various times, we will send mailings or provide other communications to you, your Physician, or your pharmacy that communicate a variety of messages, including information about Prescription and non-prescription Drug Products. These communications may include offers that enable you, as you determine, to purchase the described product at a discount. In some instances, non-UnitedHealthcare entities may support and/or provide content for these communications and offers. Only you and your Physician can determine whether a change in your Prescription and/or non-prescription Drug regimen is appropriate for your medical condition.

Special Programs

We will have certain programs in which you will receive an enhanced Benefit based on your actions such as adherence/compliance to medication or treatment regimens, and/or taking part in health management programs. You can access information on these programs by contacting us at www.myuhc.com/exchange or the telephone number on your ID card.

Are Discounts and Incentives Available to You?

From time to time, we will make access available to discounts or incentive programs. Incentive programs may be available only to targeted populations and may include other incentives.

These discount and incentive programs are not insurance and are not an insurance benefit or promise in the Policy. Your access to these programs is provided by us separately or independently from the Policy, and may be discontinued at any time. There is no additional charge for you to access these discount and incentive programs.

These programs may be offered or administered directly by us or through a third party vendor. If we receive any funds from a third party vendor in conjunction with making the discount or incentive programs available to you, we will use those funds to offset our costs of providing you access to the programs.

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy and are subject to Co-payments and/or Co-insurance and/or any applicable deductible or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is placed. Refer to the *Outpatient Prescription Drugs Schedule of Benefits* for applicable Co-payments, Co-insurance and/or any applicable deductible requirements. The Co-payment or Co-insurance you pay for a Prescription Drug Product or device will not exceed the Retail Price of the Prescription Drug Product or device.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Care Service.

Benefits are available for a refill of prescription eye drops in accordance with guidance for early refills of topical ophthalmic products by the Centers for Medicare and Medicaid Services if:

- The prescribing health care practitioner indicates on the original prescription that additional quantities of the prescription eye drops are needed;
- The refill requested by you does not exceed the number of additional quantities indicated on the original prescription by the prescribing health care practitioner; and
- The prescription eye drops prescribed by the health care practitioner are covered by the Policy.

Benefits are available for a Prescription Drug Product or device that is not included in the list of Prescription Drug Products or devices covered under the Policy and Benefits will continue at the same cost sharing requirements if a Prescription Drug Product or device prescribed to you has moved to a higher cost share if, in the judgment of the authorized prescriber:

- There is no equivalent Prescription Drug Product or device covered under the Policy; or
- An equivalent Prescription Drug Product or device covered under the Policy:
  - Has been ineffective in treating your disease or condition; or
  - Has caused or is likely to cause an adverse reaction or other harm to you.
- For a contraceptive Prescription Drug Product or device, the Prescription Drug Product or device is Medically Necessary for you to adhere to the appropriate use of the Prescription Drug Product or device.

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

Please see *Defined Terms for Outpatient Prescription Drugs* for a full description of Specialty Prescription Drug Products.

The *Outpatient Prescription Drugs Schedule of Benefits* will tell you how Specialty Prescription Drug Product supply limits apply.

Partial Supply of a Prescription Drug Product

Benefits are provided for a partial supply of a Prescription Drug Product dispensed by a Network Pharmacy if:

- The prescriber or the pharmacist determines dispensing a partial supply of a Prescription Drug Product to be in your best interest.
- The Prescription Drug Product is anticipated to be required for more than three months;
- You request or agree to a partial supply for the purpose of synchronizing the dispensing of your Prescription Drug Products;
- The Prescription Drug Product is not a Schedule II controlled dangerous substance; and
- The supply and dispensing of the Prescription Drug Product meets all prior authorization and utilization management requirements specific to the Prescription Drug Product at the time of the synchronized dispensing.

Prescription Drug Products from a Retail Network Pharmacy

Benefits are provided for Prescription Drug Products dispensed by a retail Network Pharmacy.

The *Outpatient Prescription Drugs Schedule of Benefits* will tell you how retail Network Pharmacy supply limits apply.

Depending upon your plan design, we may offer limited Network Pharmacy providers. You can confirm that your pharmacy is a Network Pharmacy by calling the telephone number on your ID card or you can access a directory of Network Pharmacies online at www.myuhc.com/exchange.

Prescription Drug Products from a Mail Order Network Pharmacy

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

Please contact us at www.myuhc.com/exchange or the telephone number on your ID card to find out if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order Network Pharmacy.

PPACA and Preventive Care Medications

Under the Patient Protection and Affordable Care Act of 2010 (PPACA), certain preventive medications are available to you at no cost, both prescription and over-the-counter (OTC). These are called PPACA Zero Cost Share Preventive Care Medications. These preventive medications are covered at no cost to you, without charging a Co-payment, Co-insurance, or deductible when:

- Prescribed by a Physician;
- Your age and/or condition is appropriate for the recommended preventive medication;
- The medication is filled at a Network Pharmacy.

Contact us at www.myuhc.com/exchange or call the number on your ID card to find out if a medication is a PPACA Zero Cost Share Preventive Care Medication.

If your health care provider determines you need a medication that is not on the PPACA Zero Cost Share Preventive Care Medication list, they can let us know your medication is Medically Necessary and provide information about your diagnosis and medication history. If you are using your medication for an appropriate condition and it is approved, it will be covered at no cost to you. If you are using it to treat another medical condition, a cost share may apply.

List of Zero Cost Share Medications

You can obtain up to a 90-day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits, of certain Prescription Drug Products which are on the List of Zero Cost Share Medications from any retail Network Pharmacy for no cost share (no cost to you). Certain Prescription Drug Products on the List of Zero Cost Share Medications may be available from a mail order Network Pharmacy. Refer to your *Schedule of Benefits* for day supply limits.

You are not responsible for paying any applicable Co-payment, Co-insurance, or deductible for Prescription Drug Products on the List of Zero Cost Share Medications unless required by state or federal law.

Outpatient Prescription Drugs Exclusions

Exclusions from coverage listed in the Policy *also* apply to this section. In addition, the exclusions listed below apply.

When an exclusion applies to only certain Prescription Drug Products, you can contact us at www.myuhc.com/exchange or the telephone number on your ID card for information on which Prescription Drug Products are excluded.

1. Outpatient Prescription Drug Products obtained from an out-of-Network Pharmacy except as a result of an Emergency or Urgent Care received out of the Service Area.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
3. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit except as it meets the requirements of Partial Supply of a Prescription Drug Product as described above.
4. Prescription Drug Products dispensed outside the United States.
5. Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
6. Experimental or Investigational or Unproven Services and medications; medications used for experimental treatments for specific diseases and/or dosage regimens determined by us to be experimental, investigational or unproven. This exclusion does not apply to the off-label use of a Prescription Drug Product if such Prescription Drug Product is recognized for treatment in any of the standard reference compendia or in the medical literature. Furthermore we shall provide Benefits for Prescription Drug Products that have been approved for sale by the *U.S. Food and Drug Administration (FDA)* whether or not the *FDA* has approved the Prescription Drug Product for use in treatment of a particular condition, to the extent that the Prescription Drug Products are not paid for by the manufacturer, distributor, or provider of that Prescription Drug Product.
7. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
8. Prescription Drug Products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
9. Any product dispensed solely for the purpose of appetite suppression or weight loss.
10. A Pharmaceutical Product for which Benefits are provided in your Policy. This includes certain forms of vaccines/immunizations. This exclusion does not apply to certain injectable drugs used for contraception.
11. Durable Medical Equipment, including certain insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your Policy. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.
12. General vitamins, except the following, which require a Prescription Order or Refill:
    - Prenatal vitamins.
    - Vitamins with fluoride.
13. Medications solely used for cosmetic purposes.
14. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Care Service.
15. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
16. Prescription Drug Products not placed on a tier of the Prescription Drug List at the time the Prescription Order or Refill is dispensed. Please see *Your Right to Request an Exception When a Medication is Not Listed on the Prescription Drug List (PDL)* in the *Schedule of Benefits* for a full description as to how to request an exception.
17. Compounded drugs that do not contain at least one ingredient that has been approved by the *U.S. Food and Drug Administration (FDA)* and requires a Prescription Order or Refill. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are placed on Tier 5.)

18. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or made up of components that are available in over-the-counter form or equivalent. This exclusion does not apply to contraceptive drugs that are available by prescription or over the counter without a prescription.
19. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by our IPMC.
20. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
21. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of Sickness or Injury, except as required by state mandate.
22. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to monthly. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
23. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to monthly. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
24. Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to monthly. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
25. Dental products. This exclusion does not apply to preventive prescription oral fluoride supplements for children.
26. A Prescription Drug Product with either:
    - An approved biosimilar.
    - A biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product.

    For the purpose of this exclusion a “biosimilar” is a biological Prescription Drug Product approved based on both of the following:
    - It is highly similar to a reference product (a biological Prescription Drug Product) and
    - It has no clinically meaningful differences in terms of safety and effectiveness from the reference product.
    - Such determinations may be made up to monthly. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
27. Diagnostic kits and products, including associated services.
28. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.
29. Certain Prescription Drug Products that are *FDA* approved as a package with a device or application, including smart package sensors and/or embedded drug sensors.
30. Drugs to treat sexual dysfunction and/or impotency.

Defined Terms for Outpatient Prescription Drugs

Annual Drug Deductible - the amount you must pay for covered Tier 2, Tier 3, Tier 4, Tier 5 and Tier 6 Prescription Drug Products in a year before we begin paying for Prescription Drug Products. The *Outpatient Prescription Drugs Schedule of Benefits* will tell you how the Annual Drug Deductible applies.

Brand-name - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that we identify as a Brand-name product, based on available data resources. This includes data sources such as Medi-Span, that classify drugs as either brand or generic based on a number of factors. Not all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician will be classified as Brand-name by us.

Chemically Equivalent - when Prescription Drug Products contain the same active ingredient.

Complex or Chronic Medical Condition - a physical, behavioral or developmental or condition that may have no known cure, is progressive or can be debilitating or fatal if left untreated or undertreated. Complex or chronic medical condition includes multiple sclerosis, hepatitis C and rheumatoid arthritis.

Designated Pharmacy - a pharmacy that has entered into an agreement with us or with an organization contracting on our behalf, to provide specific Prescription Drug Products. This may include Specialty Prescription Drug Products. Not all Network Pharmacies are Designated Pharmacies.

Generic - a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that we identify as a Generic product based on available data resources. This includes data sources such as Medi-Span, that classify drugs as either brand or generic based on a number of factors. Not all products identified as a "generic" by the manufacturer, pharmacy or your Physician will be classified as a Generic by us.

Individual and Family Plan Pharmacy Management Committee (IPMC) - the committee that we designate for placing Prescription Drug Products into specific tiers.

List of Zero Cost Share Medications - a list that identifies certain Prescription Drug Products on the Prescription Drug List (PDL) that are available at zero cost share (no cost to you). You may find the List of Zero Cost Share Medications by contacting us at www.myuhc.com/exchange or the telephone number on your ID card.

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with us or an organization contracting on our behalf to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by us as a Network Pharmacy.

A Network Pharmacy may be a:

- Retail Network Pharmacy.
- Specialty Network Pharmacy.
- Mail Order Network Pharmacy.

New Prescription Drug Product - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

- The date it is placed on a tier by our IPMC.
- December 31st of the following calendar year.

PPACA - Patient Protection and Affordable Care Act of 2010.

PPACA Zero Cost Share Preventive Care Medications - the medications or products that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Co-payment, Co-insurance or Annual Deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.

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

You may find out if a drug is a PPACA Zero Cost Share Preventive Care Medication as well as information on access to coverage of Medically Necessary alternatives by contacting us at www.myuhc.com/exchange or the telephone number on your ID card.

Prescription Drug Charge - the rate we have agreed to pay our Network Pharmacies for a Prescription Drug Product dispensed at a Network Pharmacy. The rate includes any applicable dispensing fee and sales tax.

Prescription Drug List (PDL) - a list that places into tiers medications or products that have been approved by the *U.S. Food and Drug Administration (FDA)*. This list is subject to our review and change from time to time. If the change involves the removal of a Prescription Drug Product or to a higher tier, we will provide you with 30 days written notice before it becomes effective. You may find out to which tier a particular Prescription Drug Product has been placed by contacting us at www.myuhc.com/exchange or the telephone number on your ID card.

Prescription Drug Product - a medication or product that has been approved by the *U.S. Food and Drug Administration (FDA)* and that can, under federal or state law, be dispensed only according to a Prescription Order or Refill. A Prescription Drug Product includes a medication that is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the Policy, this definition includes:

- Inhalers (with spacers).
- Insulin.
- Tobacco cessation prescription drugs.
- Certain vaccines/immunizations administered at a Network Pharmacy.
- The following diabetic supplies:
  - standard insulin syringes with needles;
  - blood-testing strips - glucose;
  - urine-testing strips - glucose;
  - ketone-testing strips;
  - certain insulin pumps;
  - lancets and lancet devices; and
  - glucose meters, excluding continuous glucose monitors.

Prescription Order or Refill - the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice allows issuing such a directive.

Rare Medical Condition - a disease or condition that affects fewer than 200,000 individuals in the United States or approximately 1 in 1,500 individuals worldwide. Rare Medical Condition includes: cystic fibrosis, hemophilia and multiple myeloma.

Retail Price - the amount a pharmacy would charge a consumer without the use of insurance, coupons, discount cards, rebates or any other sources of payment or price reduction.

Specialty Prescription Drug Product - Prescription Drug Products that are prescribed for an individual with a Complex or Chronic Medical Condition or a Rare Medical Condition that costs $600 or more for up to a 30-day supply, is not typically stocked at retail pharmacies and requires a difficult or unusual process of delivery to the patient in the preparation, handling, storage, inventory, or distribution of the drug or requires enhanced patient education, management, or support, beyond those required for traditional dispensing, before or after administration of the drug. Specialty Prescription Drug Products do not include drugs prescribed to treat diabetes, HIV or AIDS. You may access a complete list of Specialty Prescription Drug Products by contacting us at www.myuhc.com/exchange or the telephone number on your ID card.

Therapeutically Equivalent - when Prescription Drug Products have essentially the same efficacy and adverse effect profile.

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement or pricing agreed to by the pharmacy and any third party. This fee includes any applicable dispensing fee and sales tax.

Section 11: Pediatric Dental Care Services

How Do You Use This Document?

This section of the Policy provides Benefits for Covered Dental Care Services, as described below, for Covered Persons under the age of 19. Benefits under this section will end on the last day of the month the Covered Person reaches the age of 19.

What Are Defined Terms?

Because this section is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in either the Policy in *Section 8: Defined Terms* or in this section under the heading *Defined Terms for Pediatric Dental Care Services.*

When we use the words "we," "us," and "our" in this document, we are referring to Optimum Choice, Inc. When we use the words "you" and "your" we are referring to people who are Covered Persons, as the term is defined in the Policy in *Section 8: Defined Terms*.

Referral to Out-of-Network Specialist

You may request a referral to an Out-of-Network Dental Provider who is a non-Physician Specialist if a Covered Person is diagnosed with a condition or disease that requires specialized Dental Services, and:

- There is no Network Dental Provider with the professional training and expertise to treat or provide Dental Services for the condition or disease; or
- We cannot provide reasonable access to a Network Dental Provider with the professional training and expertise to treat or provide Dental Services for the condition or disease without unreasonable delay or travel.

The Covered Person or Dental Provider requesting the referral must contact us to obtain our approval of the referral.

The term “non-Physician Specialist” means a health care provider who:

- Is not a Physician;
- Is licensed or certified under the Maryland Health Occupations Article; and
- Is certified or trained to treat or provide Dental Services for a specified condition or disease in a manner that is within the scope of the license or certification of the health care provider.

What Are Covered Dental Care Services?

You are eligible for Benefits for Covered Dental Care Services listed in this section if such Dental Care Services are Necessary and are provided by or under the direction of a Network Dental Provider.

Benefits are available only for Necessary Dental Care Services. The fact that a Dental Provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a dental disease, does not mean that the procedure or treatment is a Covered Dental Service under this section.

What Is a Pre-Treatment Estimate?

If the charge for a Dental Service is expected to exceed $500 or if a dental exam reveals the need for fixed bridgework, you may notify us of such treatment before treatment begins and receive a pre-treatment estimate. If you desire a pre-treatment estimate, you or your Dental Provider should send a notice to us, via claim form, within 20 calendar days of the exam. If requested, the Dental Provider must provide us with dental x-rays, study models or other information necessary to evaluate the treatment plan for purposes of benefit determination.

We will determine if the proposed treatment is a Covered Dental Service and will estimate the amount of payment. The estimate of Benefits payable will be sent to the Dental Provider and will be subject to all terms, conditions and provisions of the Policy. Clinical situations that can be effectively treated by a less costly, clinically acceptable alternative procedure will be given a benefit based on the less costly procedure.

A pre-treatment estimate of Benefits is not an agreement to pay for expenses. This procedure lets you know in advance approximately what portion of the expenses will be considered for payment.

Does Pre-Authorization Apply?

Pre-authorization is required for orthodontic services. Speak to your Dental Provider about obtaining a pre-authorization before Dental Care Services are provided. It is your Dental Provider’s responsibility for obtaining a pre-authorization. If you do not obtain a pre-authorization, we have a right to deny your claim for failure to comply with this requirement.

Benefits for Pediatric Dental Care Services

Benefits are provided for the Dental Care Services stated in this section when such services are:

A. Necessary.

B. Provided by or under the direction of a Dental Provider.

C. Clinical situations that can be effectively treated by a less costly, dental appropriate alternative procedure will be given a Benefit based on the least costly procedure.

D. Not excluded as described in *Pediatric Dental Exclusions* below.

Benefits after Coverage Termination for Dental Services

For Covered Dental Services other than Orthodontic Services:

Coverage will be continued for a course of treatment for at least 90 days after the date coverage would otherwise end under the Policy if the treatment:

- Begins before the date coverage ends; and
- Requires two or more visits on separate day to a dentist office.

For Covered Orthodontic Dental Services:

Coverage for orthodontic dental services will be continued after the date coverage would otherwise end under the Policy:

- For at least 60 days if the orthodontist has agreed to accept or is receiving monthly payments; or
- Until the later of 60 days after the date coverage terminates or the end of the quarter in progress, if the orthodontist has agreed to accept or is receiving payment on a quarterly basis.

Benefits

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

Benefits include diagnostic services, preventative services, restorative services, endodontic services, periodontic services, removable prosthodontics, maxillofacial prosthetics, fixed prosthodontics, orthodontics for children with severe dysfunctional, handicapping malocclusion, and adjunctive general services.

We will provide coverage for periodic screening in accordance with the periodicity schedule developed by the American Academy of Pediatric Dentistry. We will provide coverage for treatment of Dental Care Services determined to be Medically Necessary for problems identified during screening or diagnostic evaluations.

Pediatric Dental Exclusions

Except as may be specifically provided in this section under the heading *Benefits for Pediatric Dental Care Services*, Benefits are not provided under this section for the following:

1. Dental Care Services received from an out-of-Network Dental Provider, except for a dental Emergency, an unforeseen Sickness, Injury, or condition that requires immediate care or as a result of a referral as described in Referral to Out-of-Network Specialist in this section.
2. Any Dental Service or Procedure not listed as a Covered Dental Service in this section under the heading *Benefits for Pediatric Dental Care Services*.
3. Dental Care Services that are not Necessary.
4. Hospitalization or other facility charges.
5. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
6. Reconstructive surgery, regardless of whether or not the surgery is related to a dental disease, Injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.
7. Any Dental Procedure not directly related with dental disease.
8. Any Dental Procedure not performed in a dental setting.
9. Procedures that are considered to be Experimental or Investigational or Unproven Services. This includes pharmacological regimens not accepted by the *American Dental Association (ADA) Council on Dental Therapeutics*. 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.
10. Drugs/medications, received with or without a prescription, unless they are dispensed and used in the dental office during the patient visit.

11. Setting of facial bony fractures and any treatment related with the dislocation of facial skeletal hard tissue.
12. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
13. Replacement of complete dentures, fixed and removable partial dentures or crowns and implants, implant crowns and prosthesis if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
14. Temporomandibular joint (TMJ) treatment and treatment for craniomandibular pain syndrome (CPS), except for surgical services for TMJ and CPS, if Medically Necessary and if there is a clearly demonstrable radiographic evidence of joint abnormality due to disease or injury.
15. Charges for not keeping a scheduled appointment without giving the dental office 24 hours notice, telephone consultations and sales tax.
16. Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled for coverage provided through this section of the Policy.
17. Dental Care Services otherwise covered under the Policy, but provided after the date individual coverage under the Policy ends, including Dental Care Services for dental conditions arising prior to the date individual coverage under the Policy ends, except as described under *Benefits After Coverage Termination for Dental Services* in this section.
18. Services rendered by a provider with the same legal residence as you or who is a member of your family, including spouse, brother, sister, parent or child.
19. Foreign Services are not covered outside of the United States.
20. Dental implants and any related procedures, pontics, bridges, inlays, onlays, and veneers, except as expressly provided in *Benefits for Pediatric Dental Care Services* in this section.
21. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
22. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (*VDO*).
23. Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service.
24. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
25. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
26. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances.
27. Services that exceed the frequency limitations as identified in this section.
28. Payment of any claim, bill, or other demand or request for payment for health care services that the appropriate regulatory board determines were provided as a result of a prohibited referral. “Prohibited referral” means a referral prohibited by *1-302 of the Maryland Health Occupations Article*.

Defined Terms for Pediatric Dental Care Services

The following definitions are in addition to those listed in *Section 8: Defined Terms* of the Policy:

Allowed Dental Amounts - Allowed Dental Amounts for Covered Dental Care Services, incurred while the Policy is in effect, are our contracted fee(s) for Covered Dental Care Services with that provider.

Covered Dental Care Service - a Dental Care Service or Dental Procedure for which Benefits are provided under this section.

Dental Provider - any dentist or dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to provide Dental Care Services, perform dental surgery or provide anesthetics for dental surgery.

Dental Care Service or Dental Procedures - dental care or treatment provided by a Dental Provider to a Covered Person while the Policy is in effect, provided such care or treatment is recognized by us as a generally accepted form of care or treatment according to prevailing standards of dental practice.

Necessary - Dental Care Services and supplies under this section which are determined by us through case-by-case assessments of care based on accepted dental practices to be appropriate and are all of the following:

- Necessary to meet the basic dental needs of the Covered Person.
- Provided in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Care Service.
- Consistent in type, frequency and duration of treatment with scientifically based guidelines of national clinical, research, or health care coverage organizations or governmental agencies that are accepted by us.
- Consistent with the diagnosis of the condition.
- Required for reasons other than the convenience of the Covered Person or his or her Dental Provider.
- Demonstrated through prevailing peer-reviewed dental literature to be either:
  - Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed; or
  - Safe with promising efficacy
    - For treating a life threatening dental disease or condition.
    - Provided in a clinically controlled research setting.
    - Using a specific research protocol that meets standards equivalent to those defined by the *National Institutes of Health*.

(For the purpose of this definition, the term life threatening is used to describe dental diseases or sicknesses or conditions, which are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a Dental Provider has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular dental disease does not mean that it is a Necessary Covered Dental Care Service as defined in this section. The definition of Necessary used in this section relates only to Benefits under this section and differs from the way in which a Dental Provider engaged in the practice of dentistry may define necessary.

Section 12: Pediatric Vision Care Services

How Do You Use This Document?

This section of the Policy provides Benefits for Vision Care Services, as described below, for Covered Persons under the age of 19. Benefits under this section will end on the last day of the month the Covered Person reaches the age of 19.

What Are Defined Terms?

Because this section is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in either the Policy in *Section 8: Defined Terms* or in this section under the heading *Defined Terms for Pediatric Vision Care Services.*

When we use the words "we," "us," and "our" in this document, we are referring to Optimum Choice, Inc. When we use the words "you" and "your" we are referring to people who are Covered Persons, as the term is defined in the Policy in *Section 8: Defined Terms*.

Benefits for Pediatric Vision Care Services

What Are the Benefit Descriptions?

Benefits

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

Frequency of Service Limits

Benefits are provided for the Vision Care Services described below, subject to *Frequency of Service* limits and Co-insurance stated under each Vision Care Service in the *Schedule of Benefits*.

Routine Vision Exam

A routine vision exam of the eyes and according to the standards of care in your area, including:

- A patient history that includes reasons for exam, patient medical/eye history, and current medications.
- Visual acuity with each eye and both eyes, far and near, with and without glasses or contact lenses (for example, 20/20 and 20/40).
- Cover test at 20 feet and 16 inches (checks how the eyes work together as a team).
- Ocular motility (how the eyes move) near point of convergence (how well eyes move together for near vision tasks, such as reading), and depth perception (3D vision).
- Pupil reaction to light and focusing.
- Exam of the eye lids, lashes, and outside of the eye.
- Refraction (when applicable), to determine power of corrective lenses for distance and near vision; objective refraction to obtain a measurement of refractive error and or subjective refraction to determine the final lens power of corrective lenses.
- Binocular testing - far and near (how well eyes work as a team).
- Tests of accommodation - how well you see up close (for example, reading).
- Tonometry, when indicated - test pressure in eye (glaucoma check).
- Ophthalmoscopic exam of the inside of the eye.
- Visual field testing.
- Color vision testing.
- Diagnosis/prognosis.
- Specific recommendations.

Post exam procedures will be performed only when materials are required.

Routine vision exams will include dilation when professionally indicated.

Eyeglass Lenses

Lenses that are placed in eyeglass frames and worn on the face to correct visual acuity limitations.

You are eligible to choose only one of either eyeglasses (*Eyeglass Lenses* and/or *Eyeglass Frames*) or *Contact Lenses* (either one pair of elective prescription contact lenses or multiple pairs of disposable prescription contact lenses). If you choose more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.

Eyeglass Frames

A structure that contains eyeglass lenses, holding the lenses in front of the eyes and supported by the bridge of the nose.

You are eligible to choose only one of either eyeglasses (*Eyeglass Lenses* and/or *Eyeglass Frames*) or *Contact Lenses* (either one pair of elective prescription contact lenses or multiple pairs of disposable prescription contact lenses). If you choose more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.

Contact Lenses

Lenses worn on the surface of the eye to correct visual acuity limitations.

Benefits include the fitting/evaluation fees, contact lenses, and follow-up care.

You are eligible to choose only one of either eyeglasses (*Eyeglass Lenses* and/or *Eyeglass Frames*) or *Contact Lenses*. If you choose more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.

Necessary Contact Lenses

Benefits are available when a Vision Care Provider has determined a need for and has prescribed the contact lens. Such determination will be made by the Vision Care Provider and not by us.

Contact lenses are necessary if you have any of the following:

- Keratoconus.
- Anisometropia.
- Irregular corneal/astigmatism.
- Aphakia.
- Facial deformity.
- Corneal deformity.
- Pathological myopia.
- Aniseikonia.
- Aniridia.
- Post-traumatic disorders.

Low Vision

Benefits are available to Covered Persons who have severe visual problems that cannot be corrected with regular lenses and only when a Vision Care Provider has determined a need for and has prescribed the service. Such determination will be made by the Vision Care Provider and not by us.

Benefits include:

- Low vision testing: Complete low vision analysis and diagnosis which includes:
  - A comprehensive exam of visual functions.
  - The prescription of corrective eyewear or vision aids where indicated.
  - Any related follow-up care.
- Low vision therapy: Subsequent low vision therapy if prescribed.
- Prescribed optical devices, such as high-power spectacles, magnifiers and telescopes.

Referral to Out-of-Network Specialist

You may request a referral to an Out-of-Network Vision Care Provider who is a non-Physician Specialist if a Covered Person is diagnosed with a condition or disease that requires specialized Vision Care Services and:

- There is no Network Vision Provider with the professional training and expertise to treat or provide Vision Care Services for the condition or disease; or

- We cannot provide reasonable access to a Network Vision Care Provider with the professional training and expertise to treat or provide Vision Care Services for the condition or disease without unreasonable delay or travel.
- The Covered Person or Vision Care Provider requesting the referral must contact us to obtain our approval of the referral.

The term “non-Physician Specialist” means a health care provider who:

- Is not a Physician;
- Is licensed or certified under the Maryland Health Occupations Article; and
- Is certified or trained to treat or provide Vision Care Services for a specified condition or disease in a manner that is within the scope of the license or certification of the health care provider.

Benefits after Coverage Termination for Vision Services

Coverage will be provided for glasses or contact lenses, according to the terms of this section, if the glasses or contact lenses:

- Were ordered before the termination date; and
- Are received within 30 days after the date of the order.

Pediatric Vision Exclusions

Except as may be specifically provided in this section under the heading *Benefits for Pediatric Vision Care Services*, Benefits are not provided under this section for the following:

1. Medical or surgical treatment for eye disease which requires the services of a Physician and for which Benefits are available as stated in the Policy.
2. Vision Care Services received from a non-UnitedHealthcare Vision Network Vision Care Provider, except as a result of a referral as described in Referral to Out-of-Network Specialist in this section.
3. Non-prescription items (e.g. Plano lenses).
4. Replacement of lost and/or stolen eyewear.
5. Replacement or repair of lenses and/or frames that have been lost or broken.
6. Optional Lens Extras not listed in this section under the heading *Benefits for Pediatric Vision Care Services.*
7. Missed appointment charges.
8. Applicable sales tax charged on Vision Care Services.
9. Orthoptics or vision therapy training and any associated supplemental testing.
10. Corrective surgical procedures such as, but not limited to, Radial Keratotomy (RK) and Photo-refractive Keratectomy (PRK).
11. Contact lenses if an eyeglass frame and eyeglass lenses are received in the same calendar year.
12. Eyeglass frame and eyeglass lenses if contact lenses are received in the same calendar year.
13. Services or treatments that are already excluded in *Section 2: Exclusions and Limitations* of the Policy.
14. Payment of any claim, bill, or other demand or request for payment for health care services that the appropriate regulatory board determines were provided as a result of a prohibited referral. “Prohibited referral” means a referral prohibited by *1-302 of the Maryland Health Occupations Article*.

Claims for Low Vision Care Services

When obtaining low Vision Care Services, you will be required to pay all billed charges directly to your Vision Care Provider. You may then seek reimbursement from us. Information about claim timelines and responsibilities in the Policy in *Section 5: How to File a Claim* applies to Vision Care Services provided under this section, except that when you submit your claim, you must provide us with all of the information identified below.

Reimbursement for Low Vision Care Services

To file a claim for reimbursement for low Vision Care Services, you must provide all of the following information:

- Your itemized receipts.
- Covered Person's name.
- Covered Person's identification number from the ID card.
- Covered Person's date of birth.

Send the above information to us:

By mail:

Claims Department

P.O. Box 30978

Salt Lake City, UT 84130

By facsimile (fax):

248-733-6060

Defined Terms for Pediatric Vision Care Services

The following definitions are in addition to those listed in *Section 8: Defined Terms* of the Policy:

Covered Contact Lens Selection - a selection of available contact lenses that may be obtained from a UnitedHealthcare Vision Network Vision Care Provider on a covered-in-full basis, subject to payment of any applicable Co-payment.

UnitedHealthcare Vision Networks - any optometrist, ophthalmologist, optician or other person designated by us who provides Vision Care Services for which Benefits are available under the Policy.

Vision Care Provider - any optometrist, ophthalmologist, optician or other person who may lawfully provide Vision Care Services.

Vision Care Service - any service or item listed in this section under the heading *Benefits for Pediatric Vision Care Services.*

Amendment: Individual Off-Exchange Qualified Health Plan Policy

Optimum Choice, Inc.

As described in this Amendment, the Qualified Health Plan Policy is modified to support coverage for Eligible Persons who wish to purchase the same Qualified Health Plan coverage off the individual exchange.

1. *Section 3: When Coverage Begins and Premiums* is replaced in its entirety with the following:

Section 3: When Coverage Begins and Premiums

How Do You Enroll?

Eligible Persons must complete and submit an application for insurance and make the required Premium payment. We will not provide Benefits for health care services that you receive before your effective date of coverage.

What If You Are Hospitalized When Your Coverage Begins?

We will pay Benefits for Covered Health Care Services when all of the following apply:

- You are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins.
- You receive Covered Health Care Services on or after your first day of coverage related to that Inpatient Stay.
- You receive Covered Health Services in accordance with the terms of this Policy

These Benefits are subject to your prior carrier's obligations under state law or contract.

You should notify us of your hospitalization within 48 hours of the day your coverage begins, or as soon as is reasonably possible. Network Benefits are available only if you receive Covered Health Services from Network providers, except for those instances described in your *Schedule of Benefits* under the heading "Continuity of Care".

Who is Eligible for Coverage?

Who is eligible to enroll and who qualifies as a Dependent will be determined by us under the terms of this Policy.

Eligible Person

Eligible Person refers to a person who meets the eligibility rules for coverage under this Policy and as determined based on information submitted in the application for coverage. When an Eligible Person enrolls, we refer to that person as a Policyholder. For a complete definition of Eligible Person and Policyholder, see *Section 8: Defined Terms*.

Eligible Persons must live within the Service Area.

Dependent

Dependent generally refers to the Policyholder's spouse and children. When a Dependent enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see *Section 8: Defined Terms*.

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

When Do You Enroll and When Does Coverage Begin?

Except as described below, Eligible Persons may not enroll themselves or their Dependents.

Annual Open Enrollment Period

The open enrollment period is the period of time when Eligible Persons can apply for insurance for themselves and their Dependents, as determined by state or federal law.

Coverage begins on the date identified in this Policy if we receive the completed application and the required Premium.

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period, as determined by state or federal law.

An individual may enroll in or may change health plans during special enrollment periods due to the following triggering events:

- Loss of minimum essential coverage.

  Loss of minimum essential coverage does not include loss due to:

  - Failure to pay Premiums on a timely basis, including COBRA premium prior to the expiration of COBRA coverage, except for circumstances in which an employer completely ceases its contributions to COBRA continuation coverage or government subsidies of COBRA continuation coverage completely cease;
  - Situations allowing for rescission of coverage (the individual performs an act, practice, or omission that constitutes fraud, or the individual makes an intentional misrepresentation of material fact); or
  - Voluntary termination.
- End of policy year for an individual covered under a non-calendar year group health plan or individual health insurance plan or qualified small employer health reimbursement arrangement (QSEHRA), even if an individual or Dependent has the option to renew or re-enroll in such coverage. The date of the loss of coverage is the last day of the plan or policy year.
- Loss of pregnancy related coverage by an individual or Dependent under the *Social Security Act (Medicaid)* or loss of access to health care services through coverage provided to a pregnant woman's unborn child.
- Loss of medically needy coverage as described under the *Social Security Act* only once per calendar year.
- An individual gains a Dependent or becomes a Dependent through marriage, birth, adoption, placement for adoption, or placement in foster care, or through a child support order or other court order. In the case of marriage, at least one spouse must meet the prior coverage requirement (as described further below) for one or more days during the 60 days preceding the date of the marriage.
- An individual's or Dependent's enrollment or non-enrollment in a health plan is:
  - Unintentional, inadvertent, or erroneous; and
  - The result of the error, misrepresentations, misconduct, or inaction of an officer, employee, or agent of the Maryland's Health Benefit Exchange or the *U.S. Department of Health and Human Services (HHS)* or its instrumentalities, or a non-Exchange entity providing enrollment assistance or conducting enrollment activities;
- An individual or Dependent adequately demonstrates to the Maryland Health Benefit Exchange that the Qualified Health Plan in which the individual or Dependent is enrolled substantially violated a material provision of the Qualified Health Plan's contract in relation to the individual or Dependent.
- An individual or Dependent is determined newly ineligible for advance payments of the premium tax credit or has become ineligible for cost-sharing reductions;
- An individual or Dependent newly gains access to an individual coverage HRA (as defined in 45 CFR 146.123(b)) or is newly provided a qualified small employer health reimbursement arrangement (QSEHRA) (as defined in section 9831(d)(2) of the Internal Revenue Code).
- An individual or Dependent gains access to a new health benefit plan as a result of a permanent move and can demonstrate meeting the prior coverage requirement for one or more days in the 60 days preceding the date of the move (as described further below).
- An individual loses a Dependent or is no longer a Dependent through divorce or legal separation as defined by state law in the state in which the divorce or legal separation occurs, or if the individual or Dependent, dies.

- An individual is a victim of domestic abuse or spousal abandonment or a Dependent or unmarried victim within a household, is enrolled in minimum essential coverage, and seeks to enroll in coverage separate from the perpetrator of the abuse or abandonment or is a Dependent of a victim of domestic abuse or spousal abandonment, on the same application as the victim, and seeks to enroll in coverage at the same time as the victim.
- An individual applies for coverage on the Maryland Health Benefit Exchange during the annual open enrollment period or due to a qualifying event, is assessed by the Maryland Health Benefit Exchange as potentially eligible for Medicaid or for the Children's Health Insurance Program (CHIP) and is determined ineligible for Medicaid or CHIP by the State Medicaid or CHIP agency either after open enrollment has ended or more than 90 days after the qualifying event or applies for coverage at the State Medicaid or CHIP agency during the annual open enrollment period, and is determined ineligible for Medicaid or CHIP after open enrollment has ended.
- A qualified individual or Dependent is enrolled in COBRA continuation coverage for which an employer is paying all or part of the premiums, or for which a government entity is providing subsidies, and the employer completely ceases its contributions to the qualified individual's or Dependent's COBRA continuation coverage or government subsidies completely cease. The triggering event is the last day of the period for which COBRA continuation coverage is paid for or subsidized, in whole or in part, by an employer or government entity.
- An individual or Dependent who becomes pregnant as of the date a Health Care Practitioner confirms the pregnancy.

Individuals who are required to demonstrate having minimum essential coverage in the 60 days prior to a triggering event can do so by demonstrating:

- They had minimum essential coverage for one or more days during the 60 days preceding the date of the triggering event;
- They had pregnancy related coverage or access to healthcare services through unborn child coverage during the 60 days preceding the date of the triggering event;
- They had medically needy coverage during the 60 days preceding the date of the triggering event;
- They are an Indian, as defined by the Indian Health Care Improvement Act;
- They lived in a foreign country or in a United States territory for one or more days during the 60 days preceding the move; or
- For one or more days during the 60 days preceding the triggering event or during their most recent preceding open enrollment or special enrollment period, lived in a service area where no Qualified Health Plan was available through the Maryland Health Benefit Exchange.

Effective Dates for Special Enrollment:

- For birth, adoption, or placement of adoption, or placement in foster care, coverage is effective on the date of birth, adoption, placement for adoption, or placement in foster care.
- For marriage, coverage is effective on the first day of the month following plan selection.
- For cases when: 1) the individual or Dependent loses minimum essential coverage, including due to an employer completely ceasing its contributions to COBRA continuation coverage or government subsidies of COBRA continuation coverage completely ceasing; 2) the individual or Dependent gains access to a health plan as a result of a permanent move; 3) the individual or Dependent loses pregnancy-related coverage; 4) the individual or Dependent loses unborn child coverage; 5) the individual or Dependent loses medically needy coverage; or 6) the individual or Dependent loses coverage under a non-calendar year group or individual plan, the effective date is as follows: if plan selection is made before or on the day of the triggering event, the effective date is on the first day of the month following the triggering event. If plan selection is made after the triggering event, coverage is effective as described in the last bullet of this section.
- For cases when: 1) the enrollment or non-enrollment was unintentional, inadvertent or erroneous and the result of error, misrepresentation, misconduct, or inaction by the Maryland Health Benefit Exchange or *HHS*; its instrumentalities, or a non-Exchange entity providing enrollment assistance or conducting enrollment activities; 2) the Qualified Health Plan substantially violated a material provision of its contract; 3) the individual or Dependent applied for coverage during the annual open enrollment period or due to a qualifying event is assessed as potentially eligible for Medicaid or CHIP and is determined ineligible for Medicaid or CHIP by the State Medicaid or CHIP agency either after open enrollment has ended or more than 60 days after the qualifying event or the

individual or Dependent applies for coverage at the State Medicaid or CHIP agency during the annual open enrollment period and is determined ineligible for Medicaid or CHIP after open enrollment has ended, coverage is effective based on the date of plan selection as described in the last bullet of this section.

- For a individual or Dependent who newly gains access to an individual coverage HRA or is newly provided a QSEHRA if the plan selection is made before the day of the triggering event, the effective date is on the first day of the month following the date of the triggering event or, if the triggering event is on the first day of a month, on the date of the triggering event. If plan selection is made on or after the date of the triggering event, the effective date is on the first day of the month following plan selection.
- For an individual who gains a Dependent or becomes a Dependent through a child support order or other court order, coverage is effective on the date the court order is effective.
- For death, coverage is effective on the first day of the month following plan selection.
- For an individual or Dependent who becomes pregnant as confirmed by a health care practitioner, coverage is effective on the 1st day of the month in which the individual receives confirmation of pregnancy by a health care practitioner.
- For all other triggering events: When selection is made between the first and fifteenth day of any month, coverage is effective on the first day of the following month. When selection is made between the sixteenth and the last day of the month, coverage is effective the first day of the second following month.

Length of Special Enrollment Periods:

- Unless stated otherwise in this section, an individual or Dependent has 60 days after the date of the triggering event to select a health plan.
- An individual or Dependent who: 1) loses minimum essential coverage; 2) is enrolled under a non-calendar year group health plan, qualified small employer health reimbursement arrangement (QSEHRA), or individual health insurance plan; 3) loses pregnancy related coverage under section 1902(a)(10)(A)(i)(IV) and (a)(10)(A)(ii)(IX) of the *Social Security Act (Medicaid*) or loses access to health care services through coverage provided to a pregnant woman's unborn child, or 4) loses medically needy coverage as described under the *Social Security Act* only once per calendar year, has 60 days before and after loss of coverage to select a Qualified Health Plan.
- A qualified individual or Dependent who is enrolled in COBRA continuation coverage for which an employer is paying all or part of the premiums, or for which a government entity is providing subsidies, and the employer completely ceases its contributions to the qualified individual or Dependent's COBRA continuation coverage or government subsidies completely cease has 60 days before and after the triggering event to select a Qualified Health Plan.
- An individual or Dependent who gains access to an individual coverage HRA or is newly provided a qualified small employer health reimbursement arrangement (QSEHRA) has 60 days before the triggering event to select a Qualified Health Plan, unless the HRA or QSEHRA was not required to provide the notice setting forth its terms to such individual or enrollee at least 90 days before the beginning of the plan year, as specified in 45 CFR 146.123(c)(6), 26 CFR 54.9802-4(c)(6), and 29 CFR 2590.702-2(c)(6) or section 9831(d)(4) of the Internal Revenue Code, as applicable, in which case the individual or Dependent has 60 days before or after the triggering event to select a Qualified Health Plan.
- An individual or Dependent who becomes pregnant as confirmed by a health care practitioner has 90 days from the date the health care practitioner confirms the pregnancy to select a Qualified Health Plan.

Adding New Dependents

Policyholders may apply for insurance for Dependents only as described below.

The Policyholder must notify us of a new Dependent to be added to this Policy. Additional Premium may also be required, and it will be calculated from the date coverage is effective.

Dependent Eligibility

Your Dependents become eligible for insurance on the later of following:

- The date you became insured under this Policy.
- The first day of the first full calendar month after the date of becoming your Dependent.

Effective Date for Initial Dependents:

The effective date for your initial Dependents, if any, is shown on the face page of the Policy. Only Dependents included in the application for insurance will be covered on your effective date.

Adding a Newborn Child:

A Dependent child born to you or your spouse will be covered from the time of birth until the 31st day after birth, unless you or your spouse advises us not to add the newborn child.

Adding an Adopted Child:

A Dependent child legally placed for adoption with you or your spouse will be covered from the date of placement until the 31st day after placement, unless the placement is disrupted prior to legal adoption and the child is removed from your or your spouse's custody.

As used in this provision, "placement" means the earlier of the following:

- The date that you or your spouse assume physical custody of the child for the purpose of adoption.
- The date of entry of an order granting you or your spouse custody of the child for the purpose of adoption.

Additional Premium:

Additional Premium may be required to continue coverage beyond the 31st day following the birth or placement of the child. The required Premium will be calculated from the date of birth or date of placement for adoption. Coverage of the child will terminate on the 31st day following birth or placement, unless we have received both written notice of the child’s birth or your or your spouse’s intent to adopt the child and the required premium within 90 days of the date of birth or date of placement.

Adding Other Dependents:

If you submit an application for insurance on a Dependent and you pay the required Premiums, then the effective date will be shown in the written notice to you that the Dependent is insured.

Premiums

All Premiums are payable on a monthly basis, by the Policyholder. The first Premium is due and payable on the effective date of this Policy. Subsequent Premiums are due and payable no later than the first day of the month thereafter that this Policy is in effect.

We will also accept Premium payments from the following third parties:

- Ryan White HIV/AIDS Program under title XXVI of the *Public Health Service Act*.
- Indian tribes, tribal organizations or urban Indian organizations.
- Local, State and Federal Government programs, including grantees directed by government programs to make payments on their behalf consistent with the program's statutory authority.

Each Premium is to be paid by you, or a third party identified above, without contribution or reimbursement by or on behalf of any other third party including, but not limited to, any health care provider or any health care provider sponsored organization.

Premiums shall not be pro-rated based upon your effective date of coverage. A full month's Premium shall be charged for the entire month in which your coverage becomes effective.

Upon prior written notice, we may impose an administrative fee for credit card payments. This does not obligate us to accept credit card payments. We will charge a $20 fee for any check or automatic payment deduction that is returned unpaid.

Misstatement of Age

If your age has been misstated, Benefits may be adjusted based on the relationship of the Premium paid to the Premium that should have been paid, based on the correct age.

Change or Misstatement of Residence

If you change your residence, you must notify us of your new residence. Your Premium will be based on your new residence beginning on the date determined by us. If the change in residence results in the Policyholder no longer living in the Service Area, this Policy will terminate as described in *Section 4: When Coverage Ends*.

Grace Period

A grace period of 31 days shall be granted for the payment of any Premium, during which time coverage under this Policy shall continue in force. If payment is not received within this 31-day grace period, coverage may be canceled after the 31st day and the Policyholder shall be held liable for the cost of services received during the grace period. In no event shall the grace period extend beyond the date this Policy terminates.

We may pay Benefits for Covered Health Care Services incurred during this 31-day grace period. Any such Benefit payment is made in reliance on the receipt of the full Premium due from you by the end of the grace period.

Adjustments to Premiums

We reserve the right to change the schedule of Premiums on January 1st of each calendar year. We shall give written notice of any change in Premium to the Policyholder at least 45 days prior to the effective date of the change.

2. *Section 4: When Coverage Ends* is replaced in its entirety with the following:

Section 4: When Coverage Ends

General Information about When Coverage Ends

As permitted by law, we may end this Policy and/or all similar policies for the reasons explained in this Policy.

Your right to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date, except as noted below under *Extended Coverage Related to a Claim.* For extended Benefits for pediatric dental and vision services, please see the *Pediatric Vision Services Rider* and the *Pediatric Dental Services Rider*.

When your coverage ends, we will still pay claims for Covered Health Care Services that you received before the date your coverage ended. However, once your coverage ends, we will not pay claims for any health services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended).

Unless otherwise stated, an Enrolled Dependent's coverage ends on the date the Policyholder's coverage ends.

We will refund any Premium paid and not earned due to Policy termination.

This Policy may also terminate due to changes in the actuarial value requirements under state or federal law. If this Policy terminates for this reason, a new Policy, if available, may be issued to you.

You may keep coverage in force by timely payment of the required Premiums under this Policy or under any subsequent Coverage you have with us.

This Policy will renew on January 1 of each calendar year. However, we may refuse renewal if any of the following occur:

- We refuse to renew all policies issued on this form, with the same type and level of Benefits, to residents of the state where you then live, as explained under *The Entire Policy Ends* below.
- There is fraud or intentional misrepresentation made by or with the knowledge of a Covered Person in filing a claim for Benefits, as explained under *Fraud or Intentional Misrepresentation* below.
- Your eligibility would otherwise be prohibited under applicable law.

Events Ending Your Coverage

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

  Your coverage ends on the date this Policy ends. That date will be one of the following:

  - The date we terminate as a Qualified Health Plan Issuer.
  - The date this benefit plan is decertified as a *Qualified Health Plan*.
  - The date we specify that this Policy will terminate because the Policyholder no longer lives in the Service Area.
  - The date we specify, after we give you 90 days prior written notice, that we will terminate this Policy because we will discontinue offering and refuse to renew all policies issued on this form, with the same type and level of benefits, for all residents of the state where you reside. You will be offered an option to purchase other coverage in the individual market we offer in your state at the time of discontinuance of this Policy. This option to purchase other coverage will be on a guaranteed issue basis without regard to health status.
  - The date we specify, after we give you and the applicable state authority at least 180 days prior written notice, that we will terminate this Policy because we will discontinue offering and refuse to renew all individual policies/certificates in the individual market in the state where you reside.

- **You Are No Longer Eligible**

Your coverage ends on the date you are no longer eligible to be an Enrolled Dependent. Please refer to *Section 8: Defined Terms* for complete definitions of the terms “Eligible Person,” “Policyholder,” “Dependent” and “Enrolled Dependent.”

- **We Receive Notice to End Coverage**

  Your coverage ends on the date you request if we receive notice from you instructing us to end your coverage.

Other Events Ending Your Coverage

When any of the following happen, we will provide written notice including the termination date and the reason for termination to the Policyholder:

- **Failure to Pay**

  You fail to pay the required Premium.

- **Policyholder's Death**

  The Policyholder dies.

- **Fraud or Intentional Misrepresentation of a Material Fact**

  We will provide at least 30 days advance required notice to the Policyholder that coverage will end on the date we identify in the notice because you committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include knowingly providing incorrect information relating to another person's eligibility or status as a Dependent. You may appeal this decision during the notice period. The notice will contain information on how to appeal the decision.

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

  Your coverage will be voided/rescinded and claims will be denied if you perform an act or practice that constitutes fraud.

- **You Accept Reimbursement for Premium**

  You accept any direct or indirect contribution or reimbursement by or on behalf of any third party including, but not limited to, any health care provider or any health care provider sponsored organization for any portion of the Premium for coverage under this Policy. This prohibition does not apply to the following third parties:

  - Ryan White HIV/AIDS Program under title XXVI of the *Public Health Service Act*.
  - Indian tribes, tribal organizations or urban Indian organizations
  - Local, State and Federal Government programs, including grantees directed by government programs to make payments on their behalf consistent with the program's statutory authority.

Coverage for a Disabled Dependent Child

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

- The Enrolled Dependent child is not able to support him/herself because of mental, developmental, or physical incapacity that originated before the Enrolled Dependent child attained the limiting age.
- The Enrolled Dependent child is chiefly dependent depends mainly on the Policyholder or Enrolled Dependent for support.

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

You must furnish us with proof of the medical certification of incapacity within 31 days after the child reaches the terminal age. Before we agree to this extension of coverage for the child, we may require that a Physician chosen by us examine the child. We will pay for that exam.

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

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

Extended Coverage Related to a Claim

When a Covered Person has a claim in process on the date that coverage terminates, a temporary extension of coverage will be granted for Covered Health Service related to the claim.

The temporary extension will continue until:

- The Covered Person is released from the care of a Physician for a condition that is the basis of the claim; or
- 12 months from the date coverage under the Policy would otherwise have terminated whichever occurs first.

Reinstatement

When coverage under this Policy terminates for any reason, we will not reinstate coverage. You must make application for coverage under another Policy.

3. The definition of Eligible Person in *Section 8: Defined Terms* is replaced with the following:

Eligible Person - a person who meets the eligibility requirements for coverage under this Policy and as determined based on information submitted in the application. An Eligible Person must live within the Service Area.

_____

(Name and Title)