[[1]Applies to SHOP Plans.]

Small Business Health Options Program

(SHOP Exchange)

Certificate of Coverage

MAMSI Life and Health Insurance Company

What Is the Certificate of Coverage?

[[1]Include for Off Exchange plans only]

[[2]Include for SHOP Plans only]

This *Certificate of Coverage (Certificate)* is part of the Policy that is a legal document between MAMSI Life and Health Insurance Company and the Group. The *Certificate* describes Covered Health Care Services, subject to the terms, conditions, exclusions and limitations of the Policy. We issue the Policy based on [[1]the Group's Application and] payment of the required Policy Charges[[2]by the SHOP Exchange from funds obtained by the Group].

In addition to this *Certificate,* the Policy includes:

- The *Schedule of Benefits*.
- [[1]The Group's Application.]
- [[2]The Group's SHOP Exchange *Application*.]
- Riders, including the *Pediatric Dental Services Rider* and the *Pediatric Vision Care Services Rider.*
- Amendments.

You can review the Policy at the Group's office during regular business hours.

Can This Certificate Change?

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

A change in the Policy is not valid:

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

Other Information You Should Have

We have the right to change, interpret, withdraw or add Benefits, or to end the Policy, as permitted by law, without your approval.

On its effective date, this *Certificate* replaces and overrules any *Certificate* that we may have previously issued to you. This *Certificate* will in turn be overruled by any *Certificate* we issue to you in the future.

The Policy will take effect on the date shown in the Policy. Coverage under the Policy starts at 12:01 a.m. and ends at 12:00 midnight in the time zone of the Group's location. The Policy will remain in effect as long as the Policy Charges are paid when they are due, subject to *Section 4: When Coverage Ends*.

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We are delivering the Policy in Maryland. The Policy is subject to the laws of the state of Maryland and ERISA, unless the Group is not a private plan sponsor subject to ERISA. To the extent that state law applies, Maryland law governs the Policy.

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Introduction to Your Certificate

This *Certificate* and the other Policy documents describe your Benefits, as well as your rights and responsibilities, under the Policy.

What Are Defined Terms?

Certain capitalized words have special meanings. We have defined these words in *Section 9: Defined Terms*.

When we use the words "we," "us," and "our" in this document, we are referring to MAMSI Life and Health Insurance Company. When we use the words "you" and "your," we are referring to people who are Covered Persons, as that term is defined in *Section 9: Defined Terms*.

How Do You Use This Document?

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

Review the Benefit limitations of this *Certificate* by reading the attached *Schedule of Benefits* along with *Section 1: Covered Health Care Services* and *Section 2: Exclusions and Limitations*. Read *Section 8: General Legal Provisions* to understand how this *Certificate* 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 *Certificate* and any summaries provided to you by the Group, this *Certificate* 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 identification (ID) card. Throughout the document you will find statements that encourage you to contact us for more information.

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Your Responsibilities

Eligibility, Enrollment, and Required Contributions

[[1]Applies to plans offered OFF the Exchange.]

Benefits are available to you once you are enrolled for coverage under the Policy. [[1]The Group will apply the eligibility rules.]

- Your enrollment options, and the corresponding dates that coverage begins, are listed in *Section 3: When Coverage Begins*. To be enrolled and receive Benefits, both of the following apply:

[[1]Applies to plans offered OFF the Exchange. [2]Applies to SHOP plans.]

  - Your enrollment must be in accordance with the [[1]rules of the Policy issued to your Group, including the eligibility rules][[2]eligibility requirements determined by the SHOP Exchange].
  - You must qualify as a Subscriber or a Dependent as those terms are defined in *Section 9: Defined Terms*.
- You continue to receive Benefits as long as you continue to qualify as a Subscriber or Dependent as defined in *Section 9: Defined Terms* and meet the [[1]eligibility rules noted in the Policy which includes this Certificate and the Group Application][[2]eligibility requirements determined by the SHOP Exchange].
- Your Benefits are no longer available as described in *Section 4: When Coverage Ends.*

Your Group may require you to make certain payments to them, in order for you to remain enrolled under the Policy. If you have questions about this, contact your Group.

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

The 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*. Prior authorization is not required for a transfer to a special pediatric Hospital. A special pediatric Hospital means a facility in the State of Maryland that provides nonacute medical rehabilitation, therapy, and palliative services to Covered Persons:

- Under the age of 22 years; or

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- Who are at least 2 years old and under the age of 23 years and have co-occurring physical and behavioral health conditions.

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*. For Out-of-Network Benefits, you must also pay any amount that exceeds the Allowed Amount, except that this provision does not apply as listed under the *Allowed Amounts* section in the *Schedule of Benefits* - see the *IMPORTANT NOTICE* provision under the *Out-of-Network Benefits* sub-section.

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 the 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, 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 referral by us or a Network provider, we 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, 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, Benefits for that particular condition or disability are subject to your previous carrier's obligation under state law or contract provided that:

- the extended benefit under your prior coverage costs less than your new coverage under this health benefit plan; and
- there is no interruption of benefits.

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Our Responsibilities

Determine Benefits

We make administrative decisions regarding whether the Policy will pay for any portion of the cost of a health care service you intend to receive or have received. Our decisions are for payment purposes only. We do not make decisions about the kind of care you should or should not receive. You and your providers must make those treatment decisions.

We will reasonably determine the following:

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

We may assign this authority to other persons or entities that may provide administrative services for the 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 the 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

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 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 referral by us or a Network provider, we will pay Out-of-Network Providers directly.

Review and Determine Benefits in Accordance with our Reimbursement Policies

We adjudicate claims consistent with industry standards. We develop our reimbursement policy guidelines, as we determine, 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.

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- 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. 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.

You may get copies of our reimbursement policies for yourself or to share with your out-of-Network Physician or provider by contacting us at [www.myuhc.com] or 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] 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.

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Certificate of Coverage Table of Contents

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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 9: Defined Terms*.)
- You receive Covered Health Care Services while the Policy is in effect or are provided to Covered Persons under the *Extended Coverage for Total Disability* provision in *Section 4: When Coverage Ends*.
- 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 or are provided to Covered Persons under the *Extended Coverage for Total Disability* provision in *Section 4: When Coverage Ends*.
- The person who receives Covered Health Care Services is a Covered Person and meets all eligibility rules specified in the Policy which includes this *Certificate* and the Group *Application* or is receiving Benefits under the *Extended Coverage for Total Disability* provision in *Section 4: When Coverage Ends*.

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 the Policy.

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*.

Benefits are provided for nutritional counseling services provided by an appropriate licensed or registered health care professional for the treatment of medical or mental health conditions. Benefits for the services are provided under the applicable Benefit category in this section. Nutritional counseling services for preventive care are described under *Preventive Care Services*.

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 incur 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).

Benefits include a health assessment that may be completed by each Covered Person aged 18 years and older on a voluntary basis. Written feedback will be immediately provided to each Subscriber and Enrolled Dependent spouse aged 18 years and older who completes a health assessment. The feedback will include information to help lower the risks identified in the completed health assessment and based on your health assessment score, includes access to a health coach who may suggest health improvement programs such as weight loss, exercise, stress management, and nutrition programs. You may access the health assessment at [www.myuhc.com].

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."

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1. Acupuncture Services

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. Blood and Blood Products

All cost recovery expenses for blood, blood products, derivatives, components, biologics, and serums to include autologous services, whole blood, red blood cells, platelets, plasma, immunoglobin and albumin.

4. Case Management Services

Any other services approved through our case management program.

5. Cellular Therapy, Gene Therapy, and other Genetic/Molecular Therapies

Cellular Therapy, Gene Therapy, and other genetic/molecular therapies received on an inpatient or outpatient basis at a Hospital or on an outpatient basis at an Alternate Facility, a Physician's office, or in your home.

Please refer to *Pharmaceutical Products - Outpatient* in this *Certificate* for Pharmaceutical Products that are not therapies aimed at Cellular Therapy, Gene Therapy, and other genetic/molecular therapies.

You can call us at the telephone number on your ID card for information about our specific guidelines regarding Benefits for Cellular Therapy, Gene Therapy, and other genetic/molecular therapies.

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6. Chiropractic Services

Chiropractic services must be performed by a Physician or by a licensed therapy provider. Benefits under this section include chiropractic services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility.

7. Controlled 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 trial protocol, to take part in the qualifying clinical trial. Further, your referring health care professional has concluded your participation in the approved clinical trial is appropriate to treat your disease or condition based on the trial protocol.

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.

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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)*.
  - *U.S. Food and Drug Administration (FDA)*.
  - 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.

8. 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.

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

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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.

Benefits for treatment of accidental Injury are limited to Medically Necessary dental services such as restoration of the tooth or teeth or the initial placement of a bridge or denture to replace the tooth or teeth injured or last as a direct and sole result of the accidental Injury.

Benefits after Coverage Termination for Dental 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.

9. Dental Services - Hospital and Ambulatory Facility Charges Related to Dental Care

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.

10. Detoxification Services

Detoxification services received on an inpatient or outpatient basis.

11. Diabetes Services

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

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services 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.

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Diabetes self-management training includes training provided to you after the diagnosis of 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 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 Items

Insulin pumps and supplies, continuous glucose monitors and all other medically appropriate and necessary equipment and supplies based upon your medical needs 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.

An insulin pump is subject to all the conditions of coverage stated under *Durable Medical Equipment (DME), Orthotics and Supplies*. Benefits for blood glucose meters including continuous glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described in *Section 10: Prescription Drug Products.*

12. Durable Medical Equipment (DME), Orthotics and Supplies

Benefits are provided for DME and certain orthotics and supplies. 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 and Supplies

Examples of DME and supplies include:

- Equipment to help mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Negative pressure wound therapy pumps (wound vacuums).
- Nebulizers and peak flow meters.
- Mechanical equipment needed for the treatment of long term or sudden respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related needed supplies as described under *Diabetes Services*.
- External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this *Certificate*.

Benefits also include dedicated speech generating devices and tracheo-esophageal voice devices required for treatment of severe speech impairment or lack of speech directly due to Sickness or

SAMPLE

Injury. Benefits for the purchase of these devices are available only after completing a required three-month rental period. Benefits are limited as stated in the *Schedule of Benefits*.

Orthotics

Orthotic braces, including needed changes to shoes to fit braces and necessary training to use the orthotics. Braces that stabilize an injured body part and braces to treat curvature of the spine are a Covered Health Care Service.

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

Benefits are available for repairs and replacement, except 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 *Certificate*.

13. 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 is *Section 9: 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 services are provided on an out-of-network basis;
- Without regard to whether the health care provider furnishing the emergency services is a Network provider or a Network Emergency Facility, as applicable, with respect to the services;
- If the emergency 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 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 services provided for a condition that is not an emergency medical condition, 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.

[Applies to all plan designs unless declined by a group that is a bona fide religious organization and the coverage conflicts with the bona fide religious beliefs and practices of that organization.]

[14.] [Family Planning Services

Family planning services include the following:

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- Prescription contraceptive drugs or devices that require the administration of a physician or other skilled provider. Prescription drugs or devices, including FDA-approved contraceptive drugs, that are available over the counter or by prescription that are capable of self-administration are covered in *Section 10: Prescription Drug Products*;
- Coverage for the insertion or removal of contraceptive devices;
- Medically Necessary exam associated with the use of contraceptive drugs or devices; and.
- Voluntary sterilization is covered under this benefit.

For the purpose of this Benefit, "family planning" means counseling, implanting or fitting birth control devices, and follow-up visits after a Covered Person selects a birth control method.

With respect to women, any service provided under this Benefit which is considered preventive care as provided for in comprehensive guidelines supported by the Health Resources and Services Administration would be provided as described below under Preventive Care Services.]

[Applies to all plan designs unless declined by a group that is a bona fide religious organization and the coverage conflicts with the bona fide religious beliefs and practices of that organization.]

[15.] [Fertility Preservation for Iatrogenic Infertility

Benefits are available for standard fertility preservation procedures due to the need for medical treatment that may directly or indirectly cause iatrogenic infertility with a likely side effect of infertility as established by the *American Society for Reproductive Medicine, the American College of Obstetricians and Gynecologists, or the American Society of Clinical Oncology*. Iatrogenic infertility means an impairment of fertility caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment affecting the reproductive organs or processes. Standard fertility preservation procedures means procedures to preserve fertility that are consistent with established medical practices and professional guidelines published by the American Society for Reproductive Medicine, the American College of Obstetricians and Gynecologists, or the American Society of Clinical Oncology and include the following procedures, when provided by or under the care or supervision of a Physician:

- Collection of sperm.
- Cryo-preservation of sperm.
- Ovarian stimulation, retrieval of eggs and fertilization.
- Oocyte cryo-preservation.
- Embryo cryo-preservation.

Benefits for medications related to the treatment of fertility preservation are provided as described under *Pharmaceutical Products - Outpatient* in this section or under *Section 10: Prescription Drug Products*.

Benefits are not available for elective fertility preservation.

Benefits are not available for embryo transfer.

Benefits are not available for long-term storage costs (greater than one year).]

[16.] Gender Dysphoria

Benefits for the treatment of gender dysphoria provided by or under the direction of a Physician.

For the purpose of this Benefit, "gender dysphoria" is a disorder characterized by the specific diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* published by the *American Psychiatric Association*.

SAMPLE

[17.] Habilitative Services

For purposes of this Benefit, "habilitative services" means health care services and devices that are part of a prescribed treatment plan or maintenance program to help a person with a disabling condition 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 disabling condition are not considered habilitative services. A disabling condition includes but is not limited to the following:

- Pervasive Developmental Disorders, including but not limited to:
  - Autistic Disorder/Autism Spectrum Disorder
  - Rett's syndrome
  - Asperger's syndrome
- Congenital Anomaly, including but not limited to:
  - Down syndrome
  - Cleft palate
  - Tongue tie

For Covered Persons age 0-19 years old, 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.
- Manipulative Treatment.
- 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 disabling condition 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.

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- Therapeutic recreation. This does not apply to benefits provided for Habilitative Services for autism listed above, or, for Medically Necessary Autism Spectrum Disorder services addressed in *Section 1: Covered Health Care Services, Mental Health Care and Substance-Related and Addictive Disorders Services*.
- 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:

- 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*. Habilitative services provided in your home other than by a Home Health Agency are provided as described under this section.

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

[18.] 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.

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 *Certificate*. 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.

[19.] 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 either a home health aide or licensed practical nurse and supervised by a registered nurse.

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- Provided on a part-time, Intermittent Care schedule.
- Provided when Skilled Care is required.

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.

For a mother and newborn child who have a shorter Inpatient Stay than provided under Pregnancy - Maternity Services will receive the following:

- One home visit scheduled to occur within 24 hours after discharge from the Hospital, and
- An additional home visit if prescribed by the Covered Person's attending Physician.

For a mother and newborn child who remain in the Hospital for at least the length of time provided under Pregnancy - Maternity Services will receive one home visit if prescribed by the Covered Person's attending Physician.

A home visit for a mother and newborn child described above will:

- Be provided in accordance with generally accepted standards of nursing practice for home care of a mother and newborn child;
- Be provided by a registered nurse with at least 1 year of experience in maternal and child health nursing or community health nursing with an emphasis on maternal and child health; and
- Include any services required 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.

[20.] 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.

[21.] 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 Emergency room Physicians. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

[Applies to all plan designs unless declined by a group that is a bona fide religious organization and the coverage conflicts with the bona fide religious beliefs and practices of that organization.]

SAMPLE

[22.] [Infertility Services

Services for the treatment of infertility when provided by or under the direction of a Physician, except for those infertility services that are excluded under Section 2: Exclusions and Limitations.]

[23.] Lab, X-Ray and Diagnostic - Outpatient

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

- Lab and radiology/X-ray.
- Mammography.

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.
- Diagnostic breast examination.

  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.

  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, breast ultrasound, or image-guided breast biopsy.

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.*

Please refer to your *Schedule of Benefits* under *Physician's Office Services – Sickness and Injury* for how cost shares (Co-payment, Co-insurance, and/or deductible as applicable) apply, when services are provided in a Physician's office.

[24.] Lymphedema Services

Coverage is provided for the medically necessary diagnosis, evaluation and treatment of lymphedema, including equipment, supplies, complex decongestive therapy, gradient compression garments, and self-management training and education. Gradient compression garment means a garment that is used for the treatment of lymphedema, requires a prescription and is custom fitted for the Enrolled Person for

SAMPLE

whom the garment is prescribed. Gradient compression garment does not include disposable medical supplies, including over-the-counter compression or elastic knee-high or other stocking products. Coverage for the treatment of lymphedema is subject to the same cost-sharing requirements as benefits with similar coverage.

[25.] 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, 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*.)
- Lung cancer screening or follow-up diagnostic imaging, including diagnostic ultrasound, MRI, CT scans, and image-guided biopsy, to assist in the diagnosis of lung cancer for individuals for which lung cancer screening or follow-up diagnostic imaging is recommended by the *U.S. Preventative Services Task Force*.

Please refer to your *Schedule of Benefits* under *Physician's Office Services – Sickness and Injury* for how cost shares (Co-payment, Co-insurance, and/or deductible as applicable) apply, when services are provided in a Physician's office.

[26.] Medical Foods

Benefits are provided for medical foods when ordered by a Health Care Practitioner qualified to provide diagnosis and treatment in the field of metabolic disorders.

"Medical food" means a food that is:

- Intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation; and
- Formulated to be consumed or administered enterally under the direction of a Physician or registered dietitian.

Benefits for prescription or over-the-counter formula are available when a Physician issues a prescription or written order stating the formula or product is Medically Necessary for the therapeutic treatment of a condition requiring specialized nutrients and specifying the quantity and the duration of the prescription or order. The formula or product must be administered under the direction of a Physician or registered dietitian.

[27.] Mental Health Care and Substance-Related and Addictive Disorders Services

The Mental Health/Substance-Related and Addictive Disorders Delegate (the Delegate) administers Benefits for Mental Health and Substance-Related and Addictive Disorders Services. If you need assistance with coordination of care, locating a provider, and confirmation that services you plan to receive are Covered Health Care Services, you can contact the Delegate at the telephone number on your ID card.

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 through telehealth. All services must be provided by or under the direction of a behavioral health provider who is properly licensed, registered, or certified and qualified by law and acting within the scope of their licensure, registration or certification such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.

Benefits include the following levels of care:

- Inpatient treatment.

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- Inpatient professional fees.
- Residential Treatment.
- Partial Hospitalization/Day Treatment/High Intensity Outpatient.
- Intensive Outpatient Programs, including professional charges in a provider's office or other professional setting.
- Outpatient treatment.

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.

Benefits for detoxification services are provided as described above under *Detoxification Services*.

Services include the following:

- Diagnostic evaluations, assessment and treatment, and/or procedures (including psychological and neuropsychological testing for diagnostic 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.
- Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling.
- 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.
- 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 *Certificate*.

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

Benefits for Medically Necessary behavioral health care services provided by a health care provider will be covered when a Covered Person who 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:

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- "Behavioral health counseling services" means prevention, intervention and treatment services for the social-emotional, psychological, behavioral and physical 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.

[28.] Nutritional Services and Medical Nutrition Therapy

Benefits for nutritional counseling provided by a licensed dietician-nutritionist, Physician, Physician assistant or nurse practitioner for a Covered Person at risk due to nutritional history, current dietary intake, medication use or chronic illness or condition.

Medical nutrition therapy provided by a licensed dietician-nutritionist, working in coordination with a Physician, to treat a chronic illness or condition.

[29.] Pharmaceutical Products - Outpatient

Pharmaceutical Products 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 *Certificate*. Benefits for medication normally available by a prescription or order or refill are provided as described in *Section 10: Prescription Drug Products.*

If you require certain Pharmaceutical Products, including Specialty Pharmaceutical Products, we may direct you to a Designated Dispensing Entity. Such Designated 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.

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you must use different Pharmaceutical Product(s) and/or Prescription Drug Product(s) for which Benefits are provided as described in *Section 10: Prescription Drug Products* first.

You may find out whether a particular Pharmaceutical Product is subject to step therapy requirements by contacting us at [www.myuhc.com] or the telephone number on your ID card.

A step therapy requirement or fail-first protocol 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 disease or 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

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- Is supported by peer-reviewed medical literature; or
- Is being used to treat a symptom of or side effect from treatment of the Covered Person's stage four advanced metastatic cancer; and
- Use of the prescription drug is consistent with best practices and supported by peer-reviewed medical literature for the treatment of stage 4 advanced metastatic cancer, a condition associated with stage 4 advanced metastatic cancer, or a side effect associated with stage 4 metastatic cancer; or
- Is insulin or an insulin analog used to treat Type 1, Type 2, or gestational diabetes.

For products used for Cellular Therapy, Gene Therapy, and other genetic/molecular therapies, please refer to *Cellular Therapy, Gene Therapy, and other Genetic/Molecular Therapies* as described in this *Certificate*.

[30.] 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.

[31.] 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.

Covered Health Care Services include Genetic Counseling.

Benefits include administration of allergy injections and allergy serum.

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

[32.] Pregnancy - Maternity Services

Benefits for Pregnancy include all maternity-related medical services for prenatal care, postnatal care, delivery and any related complications. Benefits include those of a certified nurse-midwife or pediatric nurse practitioner.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Care Services include related tests and treatment.

Benefits include birthing classes, one course per Pregnancy.

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

- 48 hours for the mother and newborn child following an uncomplicated normal vaginal delivery.
- 96 hours for the mother and newborn child following an uncomplicated 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 as described above under *Home Health Care*. If the mother and newborn child remain in the Hospital for at least as long as the minimum Inpatient Stays as shown above, a single home visit will be provided if prescribed by the attending Physician as described above under *Home Health Care*. Such home visit will:

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- Be provided in accordance with generally accepted standards of nursing practice for home care of the mother and newborn child
- Be provided by a registered nurse with at least one year of experience in maternal and child health nursing or community health nursing with an emphasis on maternal and child health;
- Include any services required by an attending provider.

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.

Benefits include doula services.

[Applies to all plan designs unless abortion care services are declined by a group that is a bona fide religious organization and the coverage conflicts with the bona fide religious beliefs and practices of that organization.]

[Benefits for abortion care services: ending a Pregnancy. Your provider may prescribe medicine, do an in-office procedure, or refer you for a procedure. Please refer to your *Schedule of Benefits* under *Pregnancy – Maternity Services* and *Prescription Drug Products, Including Specialty Prescription Drug, Products from a Retail or Mail Order Pharmacy* for how cost shares (Co-payment, Co-insurance, and/or deductible as applicable) apply.]

[Applies to all plan designs unless declined by a group that is a bona fide religious organization and the coverage conflicts with the bona fide religious beliefs and practices of that organization.]

[33.] [Preimplantation Genetic Testing (PGT) and Related Services

Preimplantation Genetic Testing (PGT) performed to identify and to prevent genetic medical conditions from being passed onto offspring. To be eligible for Benefits the following must be met:

- PGT must be ordered by a Physician after Genetic Counseling.
- The genetic medical condition, if passed onto offspring, would result in significant health problems or severe disability and be caused by a single gene (detectable by PGT-M) or structural changes of a parents' chromosome (detectable by PGT-SR).
- Benefits are limited to PGT for the specific genetic disorder and the following related services when provided by or under the supervision of a Physician:
  - Ovulation induction (or controlled ovarian stimulation).
  - Egg retrieval, fertilization and embryo culture.
  - Embryo biopsy.
  - Embryo transfer.
  - Cryo-preservation and short-term embryo storage (less than one year).

Benefits are not available for long-term storage costs (greater than one year).]

[34.] 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 recommendations for breast cancer, that have in effect a rating of "A" or "B" in the recommendations of the *United States Preventive Services Task Force.*

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- Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention* with respect to the individual involved. A recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention* is considered to be:
  - In effect after it has been adopted by the director of the *Centers for Disease Control and Prevention*; and
  - For routine use if it is listed on the immunization schedules 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.*

  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 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).
- Prostate cancer screening including medically recognized diagnostic examination which shall include 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.

Note: In accordance with § 15-1A-10 of the Insurance Article, Annotated Code of Maryland, the Maryland Insurance Commissioner shall determine which recommendations and guidelines are considered to be in effect and applicable, including whether and when any subsequent updates to the recommendations and guidelines will apply.

[35.] Prosthetic Devices

External prosthetic devices that replace, in whole or in part, a limb or a body part, such as:

- Artificial arms, legs, feet, and hands.
- Artificial face, eyes, ears, and nose.
- Prosthetic devices such as leg, arm, back, or neck braces.
- Breast prosthesis for a patient who has undergone a mastectomy when prescribed by the attending physician. Benefits include mastectomy bras and breast prostheses. Benefits for the treatment of lymphedema are also covered, as described under *Lymphedema Services*.

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

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available under the applicable medical/surgical Covered Health Care Service categories in this *Certificate*.

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

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

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

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

[36.] 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.

Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that 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.

Please note that Benefits for reconstructive procedures include reconstructive breast surgery following mastectomy, including complications of all stages of mastectomy, as well as all stages of reconstructive breast surgery of the non-affected breast to achieve symmetry. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, including lymphedemas in a manner determined in consultation with the attending Physician and the patient, are provided in the same manner and at the same level as those for any other Covered Health Care Service. You can call us at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

For the purpose of this Benefit, the following terms have the following meaning:

- "Mastectomy" means the surgical removal of all or part of a breast.
- "Reconstructive breast surgery" means surgery performed as a result of a mastectomy to reestablish symmetry between the two breasts and includes augmentation mammoplasty, reduction mammoplasty and mastopexy.

[37.] Rehabilitation Services - Outpatient Therapy

Short-term outpatient rehabilitation services limited to:

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

SAMPLE

- Cardiac rehabilitation therapy for individuals who have been diagnosed with significant cardiac disease, or who have suffered a myocardial infarction, or have undergone invasive cardiac treatment immediately preceding referral for cardiac rehabilitation. 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*. Rehabilitative services provided in your home other than by a Home Health Agency are provided as described under this section. 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 rick factor modification, education and counseling.

Benefits for cardiac rehabilitation therapy and pulmonary rehabilitation therapy 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.

[38.] Scopic Procedures - Outpatient Diagnostic and Therapeutic

Diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital, 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*.

Please refer to your *Schedule of Benefits* under *Physician's Office Services – Sickness and Injury* for how cost shares (Co-payment, Co-insurance, and/or deductible as applicable) apply, when services are provided in a Physician's office.

[39.] 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:

SAMPLE

- 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 an 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 Benefits will be provided as an alternative to Medically Necessary inpatient Hospital services.

Benefits for cardiac rehabilitation therapy and pulmonary rehabilitation therapy 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.

[40.] Surgery - Outpatient

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

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

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

Examples of surgical procedures performed in a Physician's office are mole removal, ear wax removal, and cast application.

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*.)

Please refer to your *Schedule of Benefits* under *Physician's Office Services – Sickness and Injury* for how cost shares (Co-payment, Co-insurance, and/or deductible as applicable) apply, when services are provided in a Physician's office.

[41.] Surgical Morbid Obesity Treatment

Surgical treatment of morbid obesity that is:

- Recognized by the National Institutes of Health (NIH) as effective for the long-term reversal of morbid obesity; and
- Consistent with criteria approved by the *National Institutes of Health*.

For purposes of this Benefit, the term "morbid obesity" is defined as a body mass index that is:

- Greater than 40 kilograms per meter squared; or

SAMPLE

- Equal to or greater than 35 kilograms per meter squared with a comorbid medical condition including hypertension, a cardiopulmonary condition, sleep apnea, or diabetes.

"Body mass index" is defined as a practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

[42.] Telehealth Services

Covered Health Care Services delivered through the use of interactive audio, including audio-only conversations between a health care provider and a patient that results in the delivery of a billable, health care service, video, or other telecommunications or electronic technology by a health care provider to deliver a 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 Services are provided. Telehealth Services includes diagnosis, consultation, and treatment of mental health conditions and substance-related and addictive disorders.

Telehealth services received from Designated Virtual Network Providers are limited to services received outside of a medical facility (for example, from home or from work) for the diagnosis and treatment of less serious conditions (urgent on-demand care). Communication of medical information is provided in real-time between the patient and the distant Physician or health specialist. You can find a Designated Virtual Network Provider by contacting us at [www.myuhc.com] or the telephone number on your ID card.

Benefits are also provided for Remote Physiologic Monitoring.

Telehealth does not include: 1) Except as noted above, an audio-only telephone conversation between a health care provider and a patient; 2) An electronic mail message between a health care provider and a patient; or 3) A facsimile transmission between a health care provider and a patient.

[43.] Therapeutic Treatments - Outpatient

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

- Dialysis (both hemodialysis and peritoneal dialysis).
- Intravenous chemotherapy or other intravenous infusion therapy.
- Radiation oncology.

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 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*.

Please refer to your *Schedule of Benefits* under *Physician's Office Services – Sickness and Injury* for how cost shares (Co-payment, Co-insurance, and/or deductible as applicable) apply, when services are provided in a Physician's office.

[44.] Transplantation Services

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

Benefits 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, including CAR-T cell therapy for malignancies.

SAMPLE

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

Donor costs related to transplantation are Covered Health Care Services and are payable through the organ recipient's coverage under the 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.

[45.] 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*.

[46.] Urinary Catheters

Benefits for external, indwelling, and intermittent urinary catheters for incontinence or retention.

Benefits include related urologic supplies for indwelling catheters limited to:

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

SAMPLE

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 the 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.

Exclusions

1. Services that are not Medically Necessary.
2. Services performed or prescribed under the direction of a person who is not a Health Care Practitioner.
3. Services that are beyond the scope of practice of a Health Care Practitioner 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 and 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 the *Pediatric Vision Care Services Rider*.
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. 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.
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. In vitro fertilization, ovum transplants and gamete intrafallopian tube transfer, zygote intrafallopian transfer, or cryogenic or other preservation techniques used in these or similar procedures.
12. Services to reverse a voluntary sterilization procedure.

SAMPLE

13. Services for sterilization or reverse sterilization for a dependent minor. This exclusion does not apply to *U.S. Food and Drug Administration (FDA)* approved sterilization procedures for women with reproductive capacity.

14. Medical or surgical treatment or regimen for reducing or controlling weight, unless otherwise specified in the *Section 1: Covered Health Care Services*.

15. Services incurred before the effective date of coverage for a Covered Person.

16. Services incurred after a Covered Person's termination of coverage, not including any services rendered during any extension of benefits period.

17. 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.

18. 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.

19. 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.

20. Personal hygiene and convenience items, including, but not limited to, air conditioners, humidifiers, or physical fitness equipment.

21. Charges for telephone consultations (except a covered telehealth consultation), failure to keep a scheduled visit, or completion of any form.

22. Inpatient admissions primarily for diagnostic studies, unless authorized by us.

23. 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*.

24. Except for Emergency Health Care Services, services received while the Covered Person is outside the United States.

25. Immunizations related to foreign travel.

26. Unless otherwise specified in *Section 1: Covered Health Care Services* or in the *Pediatric Dental Services Rider,* 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.

27. 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 the *Pediatric Dental Services Rider*.

28. 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.

29. Arch support, orthotic devices, in-shoe supports, orthopedic shoes, elastic supports, or exams for their prescription or fitting, unless these services are determined to be Medically Necessary.

SAMPLE

30. Inpatient admissions primarily for physical therapy, unless authorized by us.
31. Treatment of sexual dysfunction not related to organic disease.
32. Services that duplicate benefits provided under federal, State, or local laws, regulations, or programs.
33. Nonhuman organs and their implantation.
34. Non-replacement fees for blood and blood products.
35. Lifestyle improvements, including nutrition counseling, or physical fitness programs, unless included as a Covered Service.
36. Wigs or cranial prosthesis.
37. Weekend admission charges, except for emergencies and maternity, unless authorized by us.
38. Outpatient orthomolecular therapy, including nutrients, vitamins, and food supplements.
39. 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;
40. 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.
41. Services for conditions that State or local laws, regulations, ordinances, or similar provisions require to be provided in a public institution.
42. 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.
43. Physical exams required for obtaining or continuing employment, insurance, or government licensing.
44. Nonmedical ancillary services such as vocational rehabilitation, employment counseling, or educational therapy.
45. Private hospital room, unless authorized by us.
46. Private Duty Nursing, unless authorized by us.
47. Treatment for Mental Health and Substance-Related Addictive Disorder Services for the following:
    - Services by pastoral or marital counselors.
    - Therapy for sexual problems.
    - Treatment for learning disabilities or intellectual disabilities.
    - Travel time to the Covered Person's home to conduct therapy.
    - Services rendered or billed by a school, or halfway houses or members of their staff.
    - Marriage counseling.
    - Services that are not Medically Necessary.
48. Cardiac rehabilitation therapy and pulmonary rehabilitation therapy services provided at a place of service that is not equipped and approved to provide such therapies.
49. Cardiac rehabilitation therapy and pulmonary rehabilitation therapy provided as maintenance programs. Maintenance programs consist of activities that preserve the individual's present level of

SAMPLE

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.

50. 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.

51. For prescription contraceptive coverage, we will grant a request for exclusion of contraceptive Prescription Drug Products under the Policy for a Group that meets the requirements of a religious employer as defined under 45 CFR §147.131 or for a Group that meets the definition of an eligible organization as defined under 45 CFR §147.131. Such eligible organization must maintain a self-certification.

SAMPLE

Section 3: When Coverage Begins

How Do You Enroll?

[[1]Applies to plans offered OFF the Exchange. [2]Applies to SHOP plans]

Eligible Persons must complete [[1]an enrollment form] [[2]a SHOP Exchange application]. [[1]The Group will give the necessary forms to you. The Group will submit the completed forms to us, along with any required Premium.] 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 the 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. For plans that have a Network Benefit level, 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?

[[1]Applies to plans offered OFF the Exchange. [2]Applies to SHOP plans.]

[[1]Eligibility for enrollment is administered by the Group consistent with the Policy which includes this *Certificate* and Group *Application*.]

[[2]The SHOP Exchange determines who is eligible to enroll and who qualifies as a Dependent.]

Eligible Person

[[1]Applies to SHOP plans]

Eligible Person usually refers to an employee or member of the Group who meets the eligibility rules[[1], as verified by the SHOP Exchange]. When an Eligible Person enrolls, we refer to that person as a Subscriber. For a complete definition of Eligible Person, Group and Subscriber, see *Section 9: Defined Terms*.

If both spouses are Eligible Persons of the Group, each may enroll as a Subscriber or be covered as an Enrolled Dependent of the other, but not both.

Dependent

Dependent generally refers to the Subscriber's spouse and children. When a Dependent enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see *Section 9: Defined Terms*.

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

If both parents of a Dependent child are enrolled as a Subscriber, only one parent may enroll the child as a Dependent.

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When Do You Enroll and When Does Coverage Begin?

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

[Below Enrollment provisions apply to plans offered OFF the Exchange]

[Initial Enrollment Period

When the Group purchases coverage under the Policy from us, the Initial Enrollment Period is the first period of time when Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date shown in the Policy. We must receive the completed enrollment form within 31 days of the date the Eligible Person becomes eligible and any required Premium on the effective date.

Open Enrollment Period

The Group sets the Open Enrollment Period of at least 30 days. During the Open Enrollment Period, Eligible Persons can enroll themselves and their Dependents.

During the Open Enrollment Period, Eligible Persons can:

- Enroll themselves and their Dependents.
- Discontinue enrollment in a health benefit plan offered by the Group; or
- Change enrollment in a health benefit plan offered by the Group to a different health benefit plan offered by the Group

Coverage begins on the date identified by the Group. We must receive the completed enrollment form within 31 days of the date the Eligible Person becomes eligible and any required Premium on the effective date.

New Eligible Persons

Coverage for a new Eligible Person and his or her Dependents begins on the date agreed to by the Group in accordance with the eligibility rules. We must receive the completed enrollment form within 31 days of the date the Eligible Person becomes eligible and any required Premium on the effective date.

Adding New Dependents

Subscribers may enroll Dependents who join their family because of any of the following events:

[[1]Applies when group decides to include domestic partners.]

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- Legal guardianship.
- Court or administrative order.
- [[1]Registering a Domestic Partner.]

In addition, the following rules apply in accordance with state law:

- An Eligible Person may enroll when she/he acquires new Dependents.
- A newborn Dependent child is covered automatically from the moment of birth for at least 31 days.

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- A newly adopted Dependent child is covered automatically from the date of adoption for at least 31 days. "Date of adoption" means the earlier of a judicial decree of adoption, or the assumption of custody, pending adoption, of a prospective adoptive child by a prospective adoptive parent.
- A newly eligible Dependent child is covered automatically from the date the child is placed in court ordered custody.
- The Dependent child in the custody of the Subscriber as a result of a guardianship of more than 12 months duration granted by a court or testamentary appointment is covered automatically from the date of such appointment for at least 31 days.

If payment of a specific Premium is required to provide coverage for any of the above, we will require notification and payment of the required Premium be furnished to us within 31 days after the birth, adoption, or date of court or testamentary appointment in order to have coverage continued beyond the 31-day period.

In addition, the following rules apply in accordance with state law for a court or an administrative order:

The child of a Subscriber for whom the court or the support enforcement agency has ordered the Subscriber to provide health care coverage is covered automatically from the date of the order. The Subscriber must pay any applicable Premium necessary to provide coverage for such child.

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

- Permit the insuring parent to enroll the child in Dependents coverage and include the child in that coverage regardless of enrollment period restrictions;
- If the Policy requires that the employee be enrolled in order for the child to be enrolled and the employee is not currently enrolled, we will enroll both the employee and the child regardless of enrollment period restrictions.
- If a child has health insurance coverage through an insuring parent, we will
  - provide to the non-insuring parent membership cards, claims forms, and any other information necessary for the child to obtain benefits through the health insurance coverage; and
  - process the claims forms and make appropriate payment to the non-insuring parent, health care provider, or *Maryland Department of Health* if the non-insuring parent incurs expenses for health care provided to the child.
- In cases where the insuring parent does not enroll the child as a Dependent, permit the non-insuring parent, child support enforcement agency, or *Maryland Department of Health* to apply for enrollment on behalf of the child and include the child under the coverage regardless of enrollment period restrictions;
- We will not terminate health insurance coverage for the child unless written evidence is provided to the entity that:
  - The order is no longer in effect;
  - The child has been or will be enrolled under other reasonable health insurance coverage that will take effect on or before the effective date of the termination;
  - The employer has eliminated the Dependents coverage for all its employees; or
  - The employer no longer employs the insuring parent, except that if the parent elects to exercise the provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), coverage shall be provided for the child consistent with the employer's plan for post-employment health insurance coverage for Dependents.

For all other Dependents:

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Coverage for the Dependent begins on the date of the event. We must receive the completed enrollment form and any required Premium within 31 days of the event. If you do not enroll your Dependent during the 31-day period, you will be able to enroll your Dependent during the next Open Enrollment Period or under a special enrollment period, if applicable. See the *Open Enrollment Period* provision above and the *Special Enrollment Period* provision below.

Special Enrollment Period

[[1] Applies when group decides to include domestic partners.]

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

An Eligible Person and/or Dependent does not need to elect COBRA continuation coverage to preserve special enrollment rights. Special enrollment is available to an Eligible Person and/or Dependent even if COBRA is not elected.

A special enrollment period of 31 days applies to an Eligible Person and any Dependents when one of the following events occurs:

- An Eligible Person gains a Dependent or becomes a Dependent through marriage, birth, adoption, placement for adoption, or placement in foster care or gains a Dependent through a child support order or other court order. A Dependent spouse may enroll through special enrollment due to birth, adoption of a child, placement for adoption, placement for foster care, or through a child support order or other court order, provided the spouse is otherwise eligible for coverage. An Eligible Person may enroll when she/he acquires new Dependents.
- [[1]Registering a Domestic Partner.]

A special enrollment period of 30 days, unless otherwise noted, also applies for an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period if any of the following are true:

- An Eligible Person or Dependent becomes pregnant, as confirmed by a Health Care Practitioner. In this instance, the open enrollment period will be open for 90 days, beginning on the date the Health Care Practitioner confirms the Pregnancy.
- An Eligible Person or Dependent may enroll who loses other coverage.
- The Eligible Person/Dependents applies for coverage on the Individual Exchange during the annual open enrollment period or due to a qualifying event, are initially assessed as potentially eligible for *Medicaid* or the *Children's Health Insurance Program (CHIP)* by the Exchange, during the annual open enrollment period or due to a qualifying event, but are later determined ineligible by either the State Medicaid or CHIP agency either: after open enrollment has ended or more than 60 days after the qualifying event; or who applies for coverage at the State *Medicaid* or *CHIP* agency during the annual open enrollment period and is determined ineligible after open enrollment has ended. The enrollment period is 30 days after the qualifying event. The premium due date is the date the coverage period begins.
- Eligible Person's and/or Dependent's adequately demonstrates to the SHOP Exchange that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the Eligible Person and/or Dependent.
- The Eligible Person previously declined coverage under the Policy, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under *Medicaid or Children's Health Insurance Program (CHIP)*. The enrollment period is 60 days after the qualifying event. Coverage will begin only if we receive the completed enrollment form.
- The Eligible Person and/or Dependent lose minimum essential coverage. The date of the loss of coverage is the last day the Eligible Person and/or Dependent would have coverage under his or

SAMPLE

her previous plan or coverage. Loss of minimum essential coverage does not include the loss of coverage due to:

- Voluntary termination of coverage;
- Failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage; or
- 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 facts).

- The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period; and
  - If required by the Group and if notice of this requirement was provided to the Eligible Person, the Eligible Person and/or Dependent states in writing, at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period, that coverage under an employer-sponsored plan or group health benefit plan was the reason for declining enrollment; and
    - Coverage under the prior plan ended because of any of the following:
      - Loss of eligibility (including legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment, or employer contributions towards the coverage were terminated).
      - The employer stopped paying the contributions. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer.
      - In the case of COBRA continuation coverage, the coverage ended.
      - The plan no longer offers benefits to a class of individuals that includes the Eligible Person and/or Dependent.
- The Eligible Person and/or Dependent loses eligibility under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date coverage ended.
- Loss of Pregnancy related coverage by an Eligible Person and/or Dependent under the *Social Security Act (Medicaid)* or loses access to health care services through coverage provided to a pregnant woman's unborn child which is considered to occur on the last day the Eligible Person and/or Dependent would have Pregnancy-related coverage or access to health care services through the unborn child.
- Loss of medically needy coverage as described under the *Social Security Act* only once per calendar year per individual. The date of the loss of coverage is the last day the consumer would have medically needy coverage.
- The Eligible Person and/or Dependent gains access to a new Qualified Health Plan as the result of a permanent move and had minimum essential coverage for one or more days during the 60 days preceding the move. The Eligible Person and/or Dependent may satisfy this prior coverage requirement by demonstrating that they:
  - Had minimum essential coverage;
  - Had Pregnancy related coverage (which includes coverage for the unborn child) as described under the Social Security Act (Medicaid) or had access to health care services through coverage provided to a pregnant woman's unborn child; or
  - Had medically needy coverage described in 42 U.S.C. 1396a(a)(10)(C); or

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- Are an Indian; or
- Lived in a foreign country or in a United States territory for one or more days during the 60 days preceding the move; or
- Lived for 1 or more days during the 60 days before the permanent move or during the most recent preceding enrollment period in a service area where no qualified health plan was available through the Exchange.

- Victims of domestic abuse or spousal abandonment, including dependents within a household, who are enrolled in minimum essential coverage and seek to enroll in coverage, separate from the perpetrator of the abuse or abandonment; or who 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 or Dependent who loses coverage due to the death of an individual or Dependent.

Effective Dates for Special Enrollment:

- For birth, adoption, placement for adoption, or placement in foster care, coverage begins on the date of the event. We must receive the completed enrollment form and any required Premium within 31 days of the event unless otherwise noted above.

[[1] Applies when group decides to include domestic partners.]

- For marriage [[1]or registering a Domestic Partner] coverage is effective on the first day of the month after the individual selects a plan. We must receive the completed enrollment form and any required Premium within 31 days of the event.
- For Pregnancy, coverage will become effective on the first day of the month in which the Eligible Person or Dependent receives confirmation of Pregnancy.
- For child support or other court order, coverage is effective on the date of the court order.
- For loss of coverage or when access is gained to a Qualified Health Plan due to a permanent move, loss of minimum essential coverage, loss of Pregnancy related coverage by an Eligible Person and/or Dependent under the *Social Security Act (Medicaid),* loss of medically needy coverage or loses access to health care services through coverage provided to a pregnant woman's unborn child, the effective date is as follows: if plan selection is made before or on the date of the triggering event, the coverage effective date is the first day of the month following the date of the triggering event; and if plan selection is made after the date of the triggering event, the first day of the month after the individual selects a plan.
- For cases when the Eligible Person/Dependents were determined ineligible for the *Maryland Medical Assistance Program* or the *Maryland Children's Health Program* by the *Maryland Department of Health or* the qualified plan substantially violated a material provision of its contract, the coverage effective date is the first day of the month after the individual selects a plan.
- For an individual or Dependent who loses coverage due to the death of an individual or Dependent, coverage is effective the first day of the month after the individual selects a plan.
- For all other triggering events, the coverage effective date is the first day of the month after the individual selects a plan.

For an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period because they had existing health coverage under another plan, coverage begins on the day following the day coverage under the prior plan ends. Except as otherwise noted above, coverage will begin only if we receive the completed enrollment form and any required Premium within 30 days of the date coverage under the prior plan ended.

Length of Special Enrollment Periods:

An Eligible Person or Dependent has 30 days from a triggering event to enroll, except for the following:

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- A special enrollment period of 31 days for birth, adoption, placement for adoption, placement in foster care, or marriage.
- A special enrollment period of 31 days for loss of eligibility due to divorce, legal separation, or death.
- A special enrollment period of 60 days for loss of eligibility under a Medicaid plan or CHIP plan or if the Eligible Person or Dependent becomes eligible for assistance, with respect to coverage under the SHOP Exchange, under such Medicaid or CHIP plan.]

[Below Enrollment provisions apply to SHOP Exchange Plans]

[Initial Enrollment Period

When the Group purchases coverage under the Policy from us, the Initial Enrollment Period is the first period of time when Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date shown in the Policy. We must receive the completed enrollment form within 31 days of the date the Eligible Person becomes eligible and any required Premium on the effective date.

Open Enrollment Period

The Group sets the Open Enrollment Period. During the Open Enrollment Period, Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date identified by the Group. We must receive the completed enrollment form within 31 days of the date the Eligible Person becomes eligible and any required Premium on the effective date.

New Eligible Persons

Coverage for a new Eligible Person and his or her Dependents begins on the date agreed to by the Group. We must receive the completed enrollment form within 31 days of the date the Eligible Person becomes eligible and any required Premium on the effective date.

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period.

An Eligible Person and/or Dependent does not need to elect COBRA continuation coverage to preserve special enrollment rights. Special enrollment is available to an Eligible Person and/or Dependent even if COBRA is not elected.

A special enrollment period applies to an Eligible Person and any Dependents when one of the following events occurs:

- The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period and coverage under the prior plan:
    - Was under a COBRA continuation provision, and the coverage under that provision was exhausted; or
    - Was not under a COBRA continuation provision, and either the coverage was terminated as a result of loss of eligibility for the coverage, including loss of eligibility as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment, or employer contributions towards the coverage were terminated; and
        - Under the terms of the plan, the Eligible Employee requests enrollment not later 30 days after:
            - The date of exhaustion of COBRA coverage; or

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        - Termination of coverage or termination of employer contributions under the prior plan.

- Eligible Person and/or Dependent loses minimum essential coverage. The date of the loss of coverage is the last day the Eligible Person and/or Dependent would have coverage under his or her previous plan or coverage. Losing minimum essential coverage includes the following:
    - If required by the Group and if notice of this requirement was provided to the Eligible Person, the Eligible Person and/or Dependent states in writing, at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period, that coverage under an employer-sponsored plan or group health benefit plan was the reason for declining enrollment.

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

    - Voluntary termination of coverage;
    - Failure to pay Premiums on a timely basis, including COBRA premium prior to the expiration of COBRA coverage; or
    - Situations allowing for rescission of coverage (The individual performs an act, practice, or omission that constitutes fraud, or the individual makes and intentional misrepresentation of material fact).
- An Eligible Person or Dependent becomes pregnant, as confirmed by a Health Care Practitioner. In this instance, the open enrollment period will be open for 90 days, beginning on the date the Health Care Practitioner confirms the Pregnancy.
- An Eligible Person gains a Dependent or becomes a Dependent through marriage, birth, adoption, placement for adoption, or placement in foster care or gains a Dependent through a child support order or other court order. A Dependent spouse may enroll through special enrollment due to birth, adoption of a child, placement for adoption, placement for foster care, or through a child support order or other court order, provided the spouse is otherwise eligible for coverage.
- Eligible Person's and/or Dependent's enrollment or non-enrollment in a Qualified Health Plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, misconduct or inaction of an officer, employee, or agent of the SHOP Exchange or HHS, or its instrumentalities, or a non-Exchange entity providing enrollment assistance or conducting enrollment activities as evaluated and determined by the SHOP Exchange. In such cases, the SHOP Exchange may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction.
- A material error related to plan benefits, service area, cost sharing, or premium influenced the Eligible Person's or Dependent's decision to purchase a qualified health plan through the SHOP Exchange.
- The Eligible Person and/or Dependent gains access to a new Qualified Health Plan as the result of a permanent move and had minimum essential coverage for one or more days during the 60 days preceding the move. The Eligible Person and/or Dependent may satisfy this prior coverage requirement by demonstrating that they:
    - Had minimum essential coverage;
    - Had Pregnancy related coverage (which includes coverage for the unborn child) as described under the Social Security Act (Medicaid) or had access to health care services through coverage provided to a pregnant woman's unborn child; or
    - Had medically needy coverage described in 42 U.S.C. 1396a(a)(10)(C); or
    - Are an Indian; or
    - Lived in a foreign country or in a United States territory for one or more days during the 60 days preceding the move; or

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- Lived for 1 or more days during the 60 days before the permanent move or during the most recent preceding enrollment period in a service area where no qualified health plan was available through the Exchange.

- An Indian, as defined by the Indian Health Care Improvement Act, may enroll in a Qualified Health Plan or change from one Qualified Health Plan to another one time per month. A Dependent who is enrolled or an individual who becomes a Dependent and is enrolling in a plan on the same application as the Indian, may also enroll in a Qualified Health Plan or change from one Qualified Health Plan to another one time per month.
- Eligible Person and/or Dependent enrolled in the SHOP Exchange demonstrates to the SHOP Exchange, in accordance with *HHS* guidelines, that the Eligible Person and/or Dependent meets other exceptional circumstances.
- Victims of domestic abuse or spousal abandonment, including dependents within a household, who is enrolled in minimum essential coverage and seeks to enroll in coverage, separate from the perpetrator of the abuse or abandonment; or who 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.
- The Eligible Person/Dependents applies for coverage on the Individual Exchange during the annual open enrollment period or due to a qualifying event, are initially assessed as potentially eligible for *Medicaid* or the *Children's Health Insurance Program (CHIP)* by the Exchange, but are later determined ineligible by either the State Medicaid or CHIP agency either: after open enrollment has ended or more than 60 days after the qualifying event; or who applies for coverage at the State *Medicaid* or *CHIP* agency during the annual open enrollment period and is determined ineligible after open enrollment has ended. The enrollment period is 30 days after the qualifying event. The premium due date is the date the coverage period begins.
- Eligible Person and/or Dependent loses eligibility for coverage under a Medicaid plan or CHIP or becomes eligible for assistance, with respect to coverage under the SHOP Exchange, under a Medicaid plan or CHIP, including any waiver or demonstration project conducted under or in relation to a Medicaid plan or CHIP. Request for coverage must be made within 60 days of the date coverage ended. The premium due date will be the date coverage begins.
- If required by the Group and if notice of this requirement was provided to the Eligible Person, the Eligible Person and/or Dependent states in writing, at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period, that coverage under an employer-sponsored plan or group health benefit plan was the reason for declining enrollment.
- Loss of Pregnancy related coverage by an Eligible Person and/or Dependent under the *Social Security Act (Medicaid)* or loses access to health care services through coverage provided to a pregnant woman's unborn child which is considered to occur on the last day the Eligible Person and/or Dependent would have Pregnancy-related coverage or access to health care services through the unborn child coverage.
- At the option of the SHOP Exchange, loss of a Dependent or a Dependent is longer considered a Dependent through divorce or legal separation as defined by State law in the State in which the divorce or legal separation occurs, or the death of the Eligible Person or Dependent. The enrollment period is 31 days after the qualifying event.
- Loss of medically needy coverage as described under the Social Security Act only once per calendar year per individual. The date of the loss of coverage is the last day the consumer would have medically needy coverage.

Effective Dates for Special Enrollment:

- For birth, adoption, placement for adoption, placement in foster care, or through a child support order or other court order coverage is effective: 1) on the date of birth, adoption, placement for adoption, placement in foster care, or through a child support order or other court order; or 2) in the instances of a court order, on the date the order is effective or, if permitted by the Exchange the

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individual may select a coverage effective date of the first of the month following plan selection or based on the date plan selection is received by the SHOP Exchange as described in the last bullet of this section.

[[1] Applies when group decides to include domestic partners.]

- For marriage [[1]or registering a Domestic Partner] coverage is effective on the first day of the month following plan selection.
- For Pregnancy, coverage will become effective on the first day of the month in which the Eligible Person or Dependent receives confirmation of Pregnancy.
- For loss of coverage or when access is gained to a Qualified Health Plan due to a permanent move, loss of minimum essential coverage, loss of Pregnancy related coverage by an Eligible Person and/or Dependent under the *Social Security Act (Medicaid),* loss of medically needy coverage or loses access to health care services through coverage provided to a pregnant woman's unborn child, the effective date is as follows:
  - If plan selection is made on or before the date of the triggering event, the SHOP Exchange must ensure coverage is effective on the first day of the month after the individual selects a plan;
  - If plan selection is made after the date of the triggering event, coverage is effective the first day of the month after the individual selects a plan; or
  - For the triggering events which result 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 SHOP Exchange must ensure the coverage effective date is the first day of the month in which the triggering event occurs, at the option of the SHOP Exchange.
- For cases when; 1) there was a material error related to plan benefits, service area, cost sharing, or premium influenced the Eligible Person's/Dependent's decision to purchase a QHP through the Exchange; 2) the Eligible Person/Dependents were determined ineligible for the *Maryland Medical Assistance Program* or the *Maryland Children's Health Program* by the *Maryland Department of Health* either after open enrollment has ended or more than 60 days after the qualifying event; 3) the qualified plan substantially violated a material provision of its contract; or 4) the individual meets other exceptional circumstances; or 5) the enrollment or non-enrollment was unintentional, inadvertent or erroneous and the result of an error, misrepresentation, misconduct, or inaction of an officer, employee, or agent of the SHOP Exchange or the federal *Department of Health and Human Services*, or its instrumentalities, or a non-SHOP Exchange entity providing enrollment assistance or conducting enrollment activities. The SHOP Exchange must ensure that coverage is effective on an appropriate date based on the circumstances of the special enrollment period.
- For an individual or Dependent who loses a Dependent or is no longer considered a Dependent due to divorce or legal separation, the SHOP Exchange must ensure that coverage is effective on the first day of the month following the plan selection.
- For an individual or Dependent who loses coverage due to the death of an individual or Dependent, the SHOP Exchange must ensure that coverage is effective on the first day of the month following the plan selection.
- For cases when there are victims of domestic abuse or spousal abandonment, the SHOP Exchange must ensure that coverage is effective on the first day of the month following the plan selection.
- For all other triggering events, the SHOP Exchange must ensure that coverage is effective the first of the month following plan selection.

Length of Special Enrollment Periods:

An Eligible Person or Dependent has 30 days from a triggering event to select a Qualified Health Plan, except for the following:

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- A special enrollment period of 31 days for birth, adoption, placement for adoption, placement in foster care, or marriage.
- A special enrollment period of 60 days for loss of eligibility under a Medicaid plan or CHIP plan or if the Eligible Person or Dependent becomes eligible for assistance, with respect to coverage under the SHOP Exchange, under such Medicaid or CHIP plan.
- A special enrollment period of 30 days for an Eligible Person or Dependent who gains or maintains status as an Indian or for someone who becomes a dependent of an Indian.
- A special enrollment period of 90 days that begins on the date a Health Care Practitioner confirms pregnancy if an Eligible Person or Dependent becomes pregnant.
- A special enrollment period of 31 days, at the option of the SHOP Exchange, to an enrollee who is the Eligible Employee or the spouse of the Eligible Employee, if the enrollee loses a Dependent or is no longer considered to be a Dependent due to divorce or legal separation; or the employee or the employee's dependent dies.

Additional State Required Provisions for New Dependents

The following rules apply in accordance with state law:

- A newborn Dependent child is covered automatically from the moment of birth for at least 31 days.
- A newly adopted Dependent child is covered automatically from the date of adoption for at least 31 days. "Date of adoption" means the earlier of a judicial decree of adoption, or the assumption of custody, pending adoption, of a prospective adoptive child by a prospective adoptive parent.
- A newly eligible Dependent child is covered automatically from the date the child is placed in court ordered custody.
- The Dependent child in the custody of the Subscriber 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.

In addition, the following rules apply in accordance with state law for a court or an administrative order:

The child of a Subscriber for whom the court or the support enforcement agency has ordered the Subscriber to provide health care coverage is covered automatically from the date of the order. The Subscriber must pay any applicable Premium necessary to provide coverage for such child.

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

- Permit the insuring parent to enroll the child in Dependents coverage and include the child in that coverage regardless of enrollment period restrictions;
- If the Policy requires that the employee be enrolled in order for the child to be enrolled and the employee is not currently enrolled, the SHOP Exchange will enroll both the employee and the child regardless of enrollment period restrictions.
- If a child has health insurance coverage through an insuring parent, we will
  - provide to the noninsuring parent membership cards, claims forms, and any other information necessary for the child to obtain benefits through the health insurance coverage; and
  - process the claims forms and make appropriate payment to the noninsuring parent, health care provider, or *Maryland Department of Health* if the noninsuring parent incurs expenses for health care provided to the child.
- In cases where the insuring parent does not enroll the child as a Dependent, permit the non-insuring parent, child support enforcement agency, or *Maryland Department of Health* to apply for

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enrollment on behalf of the child and include the child under the coverage regardless of enrollment period restrictions;

Coverage will not terminate for the child unless written evidence is provided to the entity that:

- The order is no longer in effect;
- The child has been or will be enrolled under other reasonable health insurance coverage that will take effect on or before the effective date of the termination;
- The employer has eliminated the Dependents coverage for all its employees; or
- The employer no longer employs the insuring parent, except that if the parent elects to exercise the provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), coverage shall be provided for the child consistent with the employer's plan for post-employment health insurance coverage for Dependents.

Coverage for new Dependents begins on the date as determined by the SHOP Exchange.]

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Section 4: When Coverage Ends

General Information about When Coverage Ends

As permitted by law, we may end the Policy and/or all similar benefit plans at any time for the reasons explained in the 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 for Total Disability.* 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 care services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended). Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.

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

Please note that if you are subject to the *Extended Coverage* for *Total Disability* provision later in this section, entitlement to Benefits ends as described in that section.

[Applies to plans offered off the Exchange]

[What Events End Your Coverage?]

[Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

  Your coverage ends on the date the Policy ends. In this event, the Group is responsible for notifying you that your coverage has ended.

- **You Are No Longer Eligible**

  Your coverage ends on the date you are no longer eligible to be a Subscriber or Enrolled Dependent. Please refer to *Section 9: Defined Terms* for definitions of the terms "Eligible Person," "Subscriber," "Dependent" and "Enrolled Dependent."

- **We Receive Notice to End Coverage**

  The Group is responsible for providing the required notice to us to end your coverage. Your coverage ends on the [date][last day of the calendar month in which] we receive the required notice from the Group to end your coverage, or on the date requested in the notice, if later.

- **Subscriber Retires or Is Pensioned**

  The Group is responsible for providing the required notice to us to end your coverage. Your coverage ends the last day of the calendar month in which the Subscriber is retired or receiving benefits under the Group's pension or retirement plan.

  This provision applies unless there is specific coverage classification for retired or pensioned persons in the Group's *Application*, and only if the Subscriber continues to meet any applicable eligibility rules. The Group can provide you with specific information about what coverage is available for retirees.]

[Applies to SHOP plans only.]

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[What Events End Your Coverage?]

[When the following happens, we will provide written notice to the Group and Covered Persons within three business days for an electronic notice and five business days for a mailed notice. The notice will include the specific reason for termination and the effective dates for termination, as established by the SHOP Exchange. Only one notice will be sent if the Subscriber and Dependents live at the same address.

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

  Your coverage ends on the date the Policy ends.

- **We Terminate as a Qualified Health Plan Issuer**

  Your coverage ends on the date we terminate as a Qualified Health Plan Issuer.

- **This Benefit Plan is Decertified as a Qualified Health Plan**

  Your coverage ends on the date this benefit plan is decertified as a Qualified Health Plan.

- **You Are No Longer Eligible**

  Your coverage ends on the last day of the month following the month in which notice of ineligibility is sent to you by the SHOP Exchange, unless you request an earlier termination date.

- **We Receive Notice to End Coverage**

  Your coverage ends on the date you specify if you provide reasonable notice, as defined under Federal law

- **Non-Payment of Premium**

- Your coverage ends on the last day of any applicable grace period as determined by the SHOP Exchange.

- **You Change from One Qualified Health Plan to Another**

  Your coverage ends the day before the effective date of coverage in the new Qualified Health Plan.]

Fraud or Intentional Misrepresentation of a Material Fact

We will provide at least 30 days advance required notice to the Subscriber 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. Such Benefits payable to us will be reduced by the Premiums that were paid for your coverage during the time you were incorrectly covered. After the policy has been in effect for two years, it may not be contested, except for non-payment of Premium.

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:

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- 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 depends mainly on the Subscriber 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 the 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.

Extension of Coverage

A temporary extension of coverage will be granted to a Covered Person who meets one or more of the following conditions on the date the Covered Person's coverage terminates:

- The Covered Person is Totally Disabled.
- The Covered Person is undergoing treatment other than treatment for an accidental dental injury as described under *Dental Services - Accident Only* in *Section 1: Covered Health Services*.
- The Covered Person is confined in a Hospital.

The temporary extension will continue until (a) the date the Covered Person ceases to be Totally Disabled; or (b) 12 months after the date coverage terminates, whichever occurs first. No Premium will be charged for this coverage extension.

Regarding an extension of coverage due to Total Disability, we may request proof of disability at any time.

With regard to the Covered Person undergoing dental treatment in connection with an accidental injury as described under *Dental Services - Accident Only* in *Section 1: Covered Health Care Services*, the temporary extension will continue for a period of 90 days from the date coverage under the Policy would otherwise have terminated if the dental treatment:(1) begins before the date coverage terminates; and (2) requires two or more visits on separate days to the dentist's office.

Note: If the Covered Person becomes covered under another health plan on the date following the date coverage terminates under this Policy and (1) the coverage provided by the succeeding health benefit plan is provided at a cost to the individual that is less than or equal to the cost to the individual as the extended Benefit provided under this Policy and (2) the new coverage does not result in an interruption of benefits, this temporary extension of coverage does not apply.

Continuation of Coverage

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

Continuation coverage under *COBRA* (the federal *Consolidated Omnibus Budget Reconciliation Act*) is available only to Groups that are subject to the terms of *COBRA*. Contact your plan administrator to find out if your Group is subject to the provisions of *COBRA*.

If you chose continuation coverage under a prior plan which was then replaced by coverage under the Policy, continuation coverage will end as scheduled under the prior plan or in accordance with federal or state law, whichever is earlier.

We are not the Group's designated "plan administrator" as that term is used in federal law, and we do not assume any responsibilities of a "plan administrator" according to federal law.

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We are not obligated to provide continuation coverage to you if the Group or its plan administrator fails to perform its responsibilities under federal law. Examples of the responsibilities of the Group or its plan administrator are:

- Notifying you in a timely manner of the right to elect continuation coverage.
- Notifying us in a timely manner of your election of continuation coverage.

Continuation of Coverage under State Law for Surviving Spouses and Children

An Enrolled Dependent whose coverage under the Policy would otherwise terminate due to the death of the Subscriber is entitled to continue coverage as described in this section. This right to continue coverage also applies to a newborn child who is born to the Enrolled Dependent spouse after the date of the Subscriber's death. In order for an Enrolled Dependent to continue coverage, the Subscriber must have been continuously covered under the Policy (or a predecessor group policy with the same Group) for a period of at least 3 months prior to his or her death and the Enrolled Dependent spouse must have been continuously covered under the Policy (or a predecessor group policy with the same Group) for a period of at least 30 days prior to his or her death.

If the Enrolled Dependent spouse or child wishes to continue coverage, he or she must request that the Group provide an election notification form. Within 14 days of the receipt of the request, the Group will deliver or send by first-class mail an election notification form. Continuation coverage must be elected within 45 days after the date of the Subscriber's death and the Enrolled Dependent must make any required payment for coverage to the Group.

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

- Eighteen (18) months after the date continuation coverage began;
- For a Dependent child, the date coverage would otherwise terminate as described in *Section 4: When Coverage Ends;*
- The date coverage terminates for failure to make timely payment of the Premium;
- The date the Group ceases to provide Benefits to its employees under a group contract;
- The date the Covered Person becomes eligible for hospital, medical, or surgical benefits under an insured or self-insured group health benefit program or plan, other than this Policy, that is written on an expense-incurred basis or is with a health maintenance organization;
- The date the Covered Person accepts hospital, medical, or surgical coverage under a nongroup contract or policy that is written on an expense-incurred basis or is with a health maintenance organization;
- The date the Covered Person becomes entitled to benefits under Title XVIII of the Social Security Act; or
- The date the Covered Person elects to terminate coverage.

Continuation of Coverage under State Law for Divorced Spouses and Children

An Enrolled Dependent whose coverage under the Policy would otherwise terminate due to divorce from the Subscriber is entitled to continue coverage as described in this section. This right to continue coverage also applies to a newborn child who is born to the Enrolled Dependent spouse after the date that coverage would have otherwise terminated due to divorce.

If the Enrolled Dependent spouse or child wishes to continue coverage, he or she or the Subscriber must notify the Group of the divorce. This notification must be provided not later than described in (1) or (2) below.

(1) 60 days after the applicable change in status if on the date of the change the Subscriber is covered under the Policy or under another group contract issued to the same Group. In this case, coverage will be effective retroactive to the date of the applicable change in status.

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(2) 30 days after the date the insured employee becomes eligible for coverage under a group contract issued to another employer, if the insured employee becomes covered under the new employer's group contract after the applicable change in status. In this case, coverage shall be retroactive to the date of eligibility.

The Subscriber or the divorced spouse must make any required payment for coverage to the Group, either through payroll deduction or other mutually agreed upon method.

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

- For a Dependent child, the date coverage would otherwise terminate as described in *Section 4: When Coverage Ends;*
- The date the Covered Person becomes covered under any non-group insurance policy or contract that is written on an expense-incurred basis or is with a health maintenance organization;
- The date the Covered Person becomes entitled to benefits under *Title XVIII* of the *Social Security Act*;
- For an Enrolled Dependent spouse, the date the Enrolled Dependent spouse remarries; or
- The date the Covered Person elects to terminate coverage. In order to terminate coverage, the Subscriber and Enrolled Dependent spouse must jointly sign a termination statement or the Subscriber must provide the Group with a signed and sworn affidavit verifying all facts in the termination statement.
- The date the Covered Person becomes eligible for hospital, medical or surgical benefits under an insured or self-insured group health benefit program or plan, other than the group contract, that is written on an expense-incurred basis or is with a health maintenance organization.

Continuation of Coverage under State Law Due to the Subscriber's Voluntary or Involuntary Termination

Covered Persons whose coverage under the Policy would otherwise terminate due to the Subscriber's voluntary or involuntary termination from employment are entitled to continue coverage as described in this section. In order for a Covered Person to continue coverage, the Subscriber must have been continuously covered under the Policy (or a predecessor group policy with the same Group) for a period of at least 3 months prior to the voluntary or involuntary termination of employment and the Enrolled Dependent must have been covered under the Policy prior to the voluntary or involuntary termination of employment.

If a Covered Person wishes to continue coverage, he or she must request that the Group provide an election notification form. Within 14 days of the receipt of the request, the Group will deliver or send by first-class mail an election notification form. Continuation coverage must be elected within 45 days of the date of the voluntary or involuntary termination from employment and the Covered Person must make any required payment for coverage to the Group.

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

- Eighteen (18) months after the date continuation coverage began;
- For a Dependent child, the date coverage would otherwise terminate as described in *Section 4: When Coverage Ends;*
- The date coverage terminates for failure to make timely payment of the Premium;
- The date the Group ceases to provide Benefits to its employees under a group contract;
- The date the Covered Person becomes eligible for hospital, medical, or surgical benefits under an insured or self-insured group health benefit program or plan, other than this Policy, that is written on an expense-incurred basis or is with a health maintenance organization;

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- The date the Covered Person accepts hospital, medical, or surgical coverage under a nongroup contract or policy that is written on an expense-incurred basis or is with a health maintenance organization;
- The date the Covered Person becomes entitled to benefits under *Title XVIII* of the *Social Security Act*;
- The date the Covered Person elects to terminate coverage.

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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 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 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.

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.

Required Information

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

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

Optum Rx

PO Box 650629

Dallas, TX 75265-0629

SAMPLE

Payment of Benefits

We will pay Benefits within 30 days after we receive your request for payment that includes all required information. Any Allowed Amounts due to a provider may be paid directly to the provider instead of being paid to you. We will not reimburse third parties that have purchased or been assigned benefits by Physicians or other providers.

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 we have paid Benefits to the Covered Person.
- We, due to an inadvertent administrative error, have previously paid the Covered Person.
- You withdraw the assignment of Benefits before we paid the Benefits to the out-of-Network provider; or
- You paid the out-of-Network provider the amount due at the time of your service.

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.

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 and after the expiration of 3 years after the 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.

SAMPLE

Section 6: Questions, Complaints and Appeals

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

What if You Have a Question?

Call the telephone number shown on your ID card. Representatives are available to take your call during regular business hours, Monday through Friday.

What if You Have a Complaint?

Call the telephone number shown on your ID card. Representatives are available to take your call during regular business hours, Monday through Friday.

If you would rather send your complaint to us in writing, the representative can provide you with the address.

If the representative cannot resolve the issue over the phone, he/she can help you prepare and submit a written complaint. We will notify you of our decision regarding your complaint within 60 days of receiving it.

What Do The Terms In This Section Mean?

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

- "Adverse decision" is our utilization review determination that a proposed or delivered Covered Health 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 but does not include a decision concerning a Subscriber's status as a Covered Person. This includes a utilization review determination based on a prior authorization or step therapy requirement, and a denial of a request by a Covered Person for an alternative standard or a waiver of a standard to satisfy the requirements of a wellness program.
- "Adverse decision complaint" is a protest filed with the Insurance Commissioner involving an adverse decision or grievance decision concerning a Covered Person.
- "Adverse decision grievance" means a protest by you, your representative, or your health care provider on your behalf with us through our internal grievance process regarding an adverse decision.
- "Compelling reason" means to show that a potential delay in receipt of a health care service until after the Covered Person or health care provider exhausts the internal grievance process and obtains a final decision under the grievance process could result in loss of life, serious impairment to a bodily function, serious dysfunction of a bodily organ, 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 that is either; a) an adverse decision complaint, or b) a complaint as allowed under the provision entitled *Complaints* below.
- "Grievance decision" is a final determination by us that arises from an adverse decision grievance filed with us under our internal adverse decision grievance process regarding an adverse decision.
- "Health Advocacy Unit" means the Health Education and Advocacy Unit in the Division of Consumer Protection of the Office of the Attorney General.

SAMPLE

- "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 Commissioner without first filing an adverse decision grievance with us and receiving a grievance decision if:

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

Internal Adverse Decision Grievance Process

Under the law, you must exhaust our internal adverse decision grievance process before you, your representative, or your health care provider file an adverse decision complaint with the Insurance Commissioner, unless as 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 orally by telephone or with the affirmative consent by you, your representative, or your health care provider, by text, facsimile, e-mail, an online portal, or other expedited means.

We will document the adverse decision in writing after we have provided an oral 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.*

SAMPLE

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

- States at the top in prominent bold print:
  - that the notice is a denial of a requested health care service;
  - that the member may file an appeal or, in the case of a grievance decision, a complaint with the Commissioner;
  - our dedicated telephone number and e–mail address for adverse and grievance decisions; and
  - that the notice includes additional information on how to file and receive assistance for filing a complaint.
- Details concerning the specific factual basis for the denial in clear, understandable language and the reasoning used to determine that the health care service is not Medically Necessary and did not meet our criteria and standards used in conducting a utilization review.
- The specific reference, language, or requirements from the criteria and standards, including any interpretive guidelines, on which the decision is based, and will not solely use:
  - generalized terms such as “experimental procedure not covered”, “cosmetic procedure not covered”, “service included under another procedure”, or “not Medically Necessary”; or
  - language directing you to review the additional coverage criteria in the *Certificate of Coverage* or other plan documents.
- A unique identifier, business address, and business telephone number for the Medical Director who made the decision, in consultation with at least one licensed physician, who:
  - is board certified or eligible in the same specialty as the treatment under review; and
  - is knowledgeable about the requested health care service or treatment through actual clinical experience.
- For mental health and substance abuse services: a unique identifier, business address, and business telephone number for the Medical Director who made the decision, in consultation with at least one licensed physician, selected by the private review agent who:
  - is board certified or eligible in the same specialty as the treatment under review; or
  - is actively practicing or has demonstrated expertise in the substance abuse or mental health service or treatment under review.
- For dental services: a unique identifier, business address, and business telephone number for the Medical Director who made the decision, in consultation with at least one licensed dentist who is knowledgeable about the requested health care service or treatment through actual clinical experience.
- A dedicated phone number for adverse and grievance decisions.
- Written details of our internal adverse decision grievance process and procedures.
- The right for you, your representative, or your health care provider on your behalf, to file an adverse decision complaint with the Insurance Commissioner within four months of receipt of our adverse grievance decision.
- The right for you, your representative, or your health care provider on your behalf, to file an adverse decision complaint with the Insurance Commissioner without first filing an adverse decision grievance with us if you, your representative, or your health care provider acting on your behalf can demonstrate a compelling reason to do so.
- The Insurance Commissioner's address, telephone number and fax number.

SAMPLE

- The information shown below regarding assistance from the Health Advocacy Unit.

Adverse Decision Grievances

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

- The adverse decision grievance must be filed by you, your representative, or your health care provider on your behalf, with us within 180 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 working days after the filing date, unless it involves an emergency case as explained below. The "filing date" is the earlier of five days after the date the adverse decision grievance was mailed or the date of receipt. You, your representative, or your health care provider on your behalf, have the right to file an adverse decision complaint with the Insurance Commissioner, if you have not received our grievance decision on or before the 30th working day after the filing date.
- For retrospective denials (denials on health services that have already been rendered), we will render a grievance decision within 45 working days after the filing date. You, your representative, or your health care provider on your behalf, have the right to file an adverse decision complaint with the Insurance Commissioner (see below), if you have not received our grievance decision on or before the 45th working day after the filing date.
- With written permission from you, your representative, or your health care provider on your behalf, the time frame within which we must respond can be extended up to an additional 30 working days.
- If, after confirming through a complete review of any information already submitted by the health care provider, we need additional information to review the case:
  - we will notify you, your representative and/or your health care provider within five working days after the filing date;
  - we will request the specific information, including any lab or diagnostic test or other medical information that must be submitted to complete the internal grievance process; and
    - we will provide the specific reference, language, or requirements from the criteria and standards used to support the need for the additional information; and
    - provide assistance in gathering the necessary information without further delay.
- If no additional information is available or is not submitted to us, we will render a decision based on the available information.
- Except as described under the first two bullets in the *Complaints* provision above, for retrospective denials, you, your representative, or your health care provider on your behalf, must file an adverse decision grievance with us before filing an adverse decision complaint with the Insurance Commissioner, as described below.
- Notice of our grievance decision will be verbally communicated to you, your representative, or your health care provider. Written notification of our grievance decision will be sent to you, your representative and any health care provider who filed an adverse decision grievance on your behalf within five working days after the grievance decision has been made. If we uphold the adverse determination, the denial notification will include a Notice of Grievance Decision. This Notice will include the 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 Commissioner.
- If any new or additional evidence is relied upon or generated by us during the determination of the adverse decision grievance, we will provide it to you free of charge and sufficiently in advance of

SAMPLE

the due date of the response to the adverse benefit determination. Any new or additional evidence will be included in the Notice of Grievance Decision.

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 or if you, your representative or your health care provider attests to the emergency case. 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:

- 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 an adverse decision grievance under our internal adverse decision grievance process and assist you or your representative in mediating a resolution of our adverse decision.

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

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

Health Education and Advocacy Unit

Consumer Protection Division

Office of the Attorney General

[200 St. Paul Place, 16th Floor

Baltimore, MD 21202

Telephone: 410-528-1840 or toll free at 1-877-261-8807

Fax#: 410-576-6571

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

Online: marylandattorneygeneral.gov]

Medical Directors

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

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MAMSI Life and Health Insurance Company

[10175 Little Patuxent Parkway, 6th Floor

Columbia, Maryland 21044

1-800-357-1371]

Adverse Decision Complaints to the Insurance Commissioner

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

Maryland Insurance Administration

Appeals and Grievance Unit

[200 St. Paul Place, Suite 2700

Baltimore, Maryland 21202

1-800-492-6116 or 410-468-2000 or 1-800-735-2258

Fax Number 410-468-2270

E-mail: 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

Consumer Protection Division

Office of the Attorney General

[200 St. Paul Place, 16th Floor

Baltimore, MD 21202

Telephone: 410-528-1840 or toll free at 1-877-261-8807

Fax#: 410-576-6571

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

Online: marylandattorneygeneral.gov]

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

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

SAMPLE

Except for emergency cases, the time periods above for notification may be extended for a period of no longer than 30 working days if the Covered Person, Cover Person's representative, or a health care provider filing a grievance on behalf of a Covered Person agrees in writing.

Assistance from State Agencies

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

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

Consumer Complaint & Investigation

Life and Health

Maryland Insurance Administration

[200 St. Paul Place, Suite 2700

Baltimore, Maryland 21202

Telephone number: 1-800-492-6116

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

E-mail: agcomplaints.mia@maryland.gov]

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

Health Education and Advocacy Unit

Consumer Protection Division

Office of the Attorney General

[200 St. Paul Place, 16th Floor

Baltimore, MD 21202

Telephone: 410-528-1840 or toll free at 1-877-261-8807

Fax#: 410-576-6571

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

Online: marylandattorneygeneral.gov]

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;

SAMPLE

- 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: Customer Support Group, P.O. Box [933, Frederick, MD 21705]. Within thirty (30) calendar days after the appeal decision has been made, we will send you, your representative and your health care provider acting on your behalf, a written notice of the appeal decision.

Notice of an appeal decision will include the following:

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

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

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

Assistance from the Health Education and Advocacy Unit

The Health Advocacy Unit can help you 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.

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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:

Health Education and Advocacy Unit

Consumer Protection Division

Office of the Attorney General

[200 St. Paul Place, 16th Floor

Baltimore, MD 21202

Telephone: 410-528-1840 or toll free at 1-877-261-8807

Fax#: 410-576-6571

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

Online: marylandattorneygeneral.gov]

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

SAMPLE

Section 7: Coordination of Benefits

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Policy will be coordinated with those of any other plan that provides benefits to you. The language in this section is from model laws drafted by the *National Association of Insurance Commissioners (NAIC)* and represents standard industry practice for coordinating benefits.

When 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; an individually underwritten and issued, guaranteed renewable, specified disease policy, that does not provide benefits on an expense-incurred basis 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. "Specified disease policy" means Benefits only for a disease or diseases specified in the policy or for a treatment unique to a specified disease or diseases; or additional benefits for a disease or diseases specified in the policy or for treatment unique to a specified disease or diseases.

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.

SAMPLE

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.

SAMPLE

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.

SAMPLE

(3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.

(4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(a) The Plan covering the Custodial Parent.

(b) The Plan covering the Custodial Parent's spouse.

(c) The Plan covering the non-Custodial Parent.

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

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

d) (i) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in paragraph (5) applies.

(ii) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in subparagraph (a) to the dependent child's parent(s) and the dependent's spouse.

3. **Active Employee or Retired or Laid-off Employee.** The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The Plan covering the same person as a retired or laid-off employee is the Secondary 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 start of a new Plan does not include:

- A change in the amount or scope of a Plan's benefits;
- A change in the entity that pays, provides or administers the Plan's benefits; or
- A change from one type of plan to another, such as, from a single employer Plan to a multiple employer Plan.

SAMPLE

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 became 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 during a plan year 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.

SAMPLE

Section 8: General Legal Provisions

What Is Your Relationship with Us?

It is important for you to understand our role with respect to the Group's Policy and how it may affect you. We help finance or administer the Group's Policy in which you are enrolled. We do not provide medical services or make treatment decisions. This means:

- We communicate to you decisions about whether the Group's 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 *Certificate*.
- 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 and Groups?

We have agreements in place that govern the relationship between us, our Groups and Network providers, some of which are affiliated providers. Network providers enter into agreements 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.

We are not considered to be an employer for any purpose with respect to the administration or provision of benefits under the Group's Policy. We are not responsible for fulfilling any duties or obligations of an employer with respect to the Group's Policy.

The Group is solely responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).

[[1]Include for plans offered Off the Exchange. [2]Include for SHOP Exchange plans.]

- The timely payment of the Policy Charge [[1]to us][[2]to the SHOP Exchange].
- [[1]Notifying you of when the Policy ends.]
- [[2]We are responsible for notifying you of the termination of the Policy.]

When the Group purchases the Policy to provide coverage under a benefit plan governed by the *Employee Retirement Income Security Act* ("ERISA"), 29 U.S.C. §1001 et seq., we are not the plan administrator or named fiduciary of the benefit plan, as those terms are used in ERISA. If you have questions about your welfare benefit plan, you should contact the Group. If you have any questions about this statement or about your rights under ERISA, contact the nearest area office of the *Employee Benefits Security Administration, U. S. Department of Labor*.

What Is Your Relationship with Providers and Groups?

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

SAMPLE

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.

The relationship between you and the Group is that of employer and employee, Dependent or other classification as defined in the Policy.

[Applies for Off Exchange Plans only]

[Notice]

[When we provide written notice regarding administration of the Policy to an authorized representative of the Group, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Group is responsible for giving notice to you.]

Statements by Group or Subscriber

All statements made by the Group or by a Subscriber or Covered Person shall, in the absence of fraud, be deemed representations and not warranties. We will not use any statement made by the Group to void the Policy after it has been in force for two years. Once the Policy has been in effect for two years, it may not be contested, except for non-payment of Premium. A statement made by any Covered Person under the Policy relating to insurability may not be used in contesting the validity of the insurance with respect to which the statement was made after the insurance has been in force before the contest for a period of 2 years during the Covered Person's lifetime.

No statement will be used to void or reduce coverage under this Policy unless:

- The statement is contained in a written instrument signed by the Group or the Subscriber or Covered Person, and
- A copy of the statement is given to the Group, Subscriber, Covered Person or beneficiary of the Subscriber or Covered Person.

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.
- Bundled payments - certain Network providers receive a bundled payment for a group of Covered Health Care Services for a particular procedure or medical condition. The applicable 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

SAMPLE

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 the *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.

Who Interprets Benefits and Other Provisions under the Policy?

We will reasonably interpret and determine the following:

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

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

In certain circumstances, for purposes of overall cost savings or efficiency, we may 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 the Policy

To the extent permitted by law, we have the right, as we determine and without your approval, to change, interpret, withdraw or add Benefits or end the Policy.

Any provision of the Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which the Policy is delivered) is 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 group health plans under this product may only be made upon the Group's annual renewal date. Notice of renewal/uniform modifications of coverage will be provided to the Enrolling' Group 60 days prior to the Group's renewal date.

No other change may be made to the Policy unless it is made by an Amendment or Rider which has been signed by one of our officers 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 the Policy are effective upon renewal with a 60 day notice prior to the Group's renewal date.

SAMPLE

- No agent has the authority to change the Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to the Policy.

Any Amendment or Rider that reduces or eliminates Benefits under the Policy is subject to the Group's signed acceptance of such Amendment or Rider at the time of or before delivery of the Policy.

How Do We Use Information and Records?

We may use your individually identifiable health information as follows:

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

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

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

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

For complete listings of your medical records or billing statements 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 the Policy do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

SAMPLE

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 the Policy.
- All or some of the payment was made in error.

The refund equals the amount we paid in excess of the amount we should have paid under the Policy. If the refund is due from another person or organization, 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.

SAMPLE

Is There a Limitation of Action?

You cannot bring any legal action against us to recover on the policy before the expiration of 60 days after written proof of loss has been furnished 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.

What Is the Entire Policy?

[[1] Include for Off Exchange Plans only]

The Policy, this *Certificate*, the *Schedule of Benefits*, [[1]the Group's application,] and any Riders and/or Amendments, make up the entire Policy that is issued to the Group. A change in the Policy is not valid:

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

SAMPLE

Section 9: 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, or while services are being covered as a result of Continuation of Coverage, 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;
- Provided by an out-of-Network provider when no other Network provider is available who can furnish such item or service at such facility.

Annual Deductible - the total of the Allowed Amount or the Recognized Amount when applicable, you must incur 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.

[Applies to SHOP plans only]

[**Annual Open Enrollment Period** - The period of time after the Initial Enrollment Period during which Eligible Persons may enroll themselves and their Dependents under the Policy, as provided and determined by the SHOP Exchange.]

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

SAMPLE

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 and as listed in the current edition of the *International Classification of Diseases* section on *Mental and Behavioral Disorders* or the *Diagnostic and Statistical Manual of Mental Disorders* published by the *American Psychiatric Association*.

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

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

Co-insurance - the charge, stated as a percentage of the Allowed Amount 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 or 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.

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 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 *Certificate* under *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*.
- Not excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.

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

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.

SAMPLE

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

[[1] Applies when group decides to include domestic partners. [2]Applies to plans offered OFF the Exchange. [3]Applies to SHOP plans.]

Dependent - the Subscriber's legal spouse or a child of the Subscriber or the Subscriber's spouse. [[1]All references to the spouse of a Subscriber shall include a Domestic Partner, except for the purpose of coordinating Benefits with Medicare.] As described in *Section 3: When Coverage Begins*, [[2]eligibility for enrollment and qualification as a Dependent is administered by the Group consistent with the eligibility rules noted in the Policy which includes this *Certificate* and the Group *Application*][[3]the SHOP Exchange determines who is eligible to enroll and who qualifies as a Dependent]. 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 Subscriber or the Subscriber's spouse.
- A child, who is unmarried and a dependent of the Subscriber or the Subscriber'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 Subscriber or the Subscriber'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 Group is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order.*

The following conditions apply:

[[1]Insert option selected by the group.]

- 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 [[1]month] [[1]year] during which the child reaches age 26 except as provided in *Section 4: When Coverage Ends* under *Coverage for a Disabled Dependent Child.*

A child who meets the requirements set forth above ceases to be eligible as a Dependent on the last day of the [[1]month] [[1]year] during which the child reaches age 26.

The Subscriber 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.

A Dependent does not include anyone who is also enrolled as a Subscriber. No one can be a Dependent of more than one Subscriber.

[Applies when DDP designation is part of the plan.]

[Designated Diagnostic Provider - a provider and/or facility that we have identified through our designation programs as a Designated Diagnostic Provider.]

SAMPLE

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

Designated Network Benefits - the description of how Benefits are paid for certain Covered Health Care Services provided by a provider or facility that has been identified as a Designated Provider. The *Schedule of Benefits* will tell you if your plan offers Designated Network Benefits and how they apply.

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 geographic 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] 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.

[Applies when group decides to include domestic partners.]

[Domestic Partner - an individual in a relationship with another individual of the same or opposite sex, provided both individuals:

- Are at least eighteen (18) years old;
- Are not related to each other by blood or marriage within four degrees of consanguinity under civil law rule;
- Are not married or in a civil union or domestic partnership with another individual;
- Have been financially interdependent for at least six (6) consecutive months prior to application in which each individual contributes to some extent to the other individual's maintenance and support with the intention of remaining in the relationship indefinitely; and
- Share a common primary residence.

[[1]Include if Group requires proof of domestic partnership.]

[[1]Documents must be furnished proving that the Domestic Partners are (i) financially interdependent, and (ii) share a common primary residence. Only one documentation of proof is required from each of the following two lists:

Financial Interdependence

- Joint bank account or credit account;
- Designation as the primary beneficiary for life insurance or retirement benefits of the Domestic Partner;
- Designation as primary beneficiary under the Domestic Partner's will;
- Mutual assignments of valid durable powers of attorney under *Estates and Trusts Article*, §13-601 et seq., *Annotated Code of Maryland*;
- Mutual valid written advanced directives under *Health General Article §5-601* et seq., *Annotated Code of Maryland*; approving the other domestic partners as health care agent;

SAMPLE

- Joint ownership or holding of investments; or
- Joint ownership or lease of a motor vehicle.

Common Primary Residence

- Common ownership of the primary residence via joint deed or mortgage agreement;
- Common leasehold interest in the primary residence;
- Driver's license or State-issued identification listing a common address; or
- Utility or other household bill with both the name of the insured and the name of the Domestic Partner appearing.]

[[2]Applies if group requires signed affidavit.]

[[2]The Subscriber and Domestic Partner must jointly sign the required affidavit of Domestic Partnership.]]

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 - 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 Employee - an employee of the Group who, at the option of the Group, may include:

- Only Full-Time Employees; or
- Full-Time Employees and Part-Time Employees.

[[1]Applies to plans offered OFF the Exchange. [3]Applies to SHOP plans.]

Eligible Person - an employee of the Group or other person connected to the Group who meets the eligibility rules [[1]in accordance with the Policy which includes this *Certificate* and the Group *Application*][[2]shown by the SHOP Exchange]. An Eligible Person must live within the United States.

Emergency - a medical condition, including a Mental Illness or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such 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:

SAMPLE

- 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 of an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency;
- Within the capabilities of the staff and facilities available at the Hospital or the 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 examination or treatment is furnished); and
- Except as provided in the fourth bullet item 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 or outpatient stay with respect to the Visit in which the services described in the first bullet item above are furnished.
- The covered services described in the third bullet item above are not included as Emergency Health Care Services if all of the following conditions are met:
  - 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 individual's medical condition;
  - 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 the sub-set items below, as applicable;
    - 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 enrollee may be referred, at their option, to such a Network Provider.
    - In the case of an Out-of-Network Emergency Facility, the written notice must include the good faith estimated amount that the individual may 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);
  - The individual (or an Authorized Representative of such individual) is in a condition to receive the information described in the second sub-bullet item 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
  - The covered services are not rendered by an on-call physician or hospital-based physician who has obtained an assignment of benefits.

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

Experimental Service(s) - services that are not recognized as efficacious as that term is defined in the edition of the I*nstitute of Medicine Report on Assessing Medical Technologies* that is current when the care is rendered. Experimental Services do not include controlled clinical trials as that term is described in *Section 1: Covered Health Care Services* under *Controlled Clinical Trials*. If you are not a participant in a qualifying clinical trial, as described under *Controlled Clinical Trials* in *Section 1: Covered Health Care Services*, and have a Sickness or condition that is likely to cause death within one year of the request for treatment we may, in our discretion, consider an otherwise Experimental Service to be a Covered Health

SAMPLE

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

Full-Time Employee - with respect to a calendar month, an employee of the Group who works, on average, at least 30 hours per week. Full-time employee does not include a seasonal employee as defined in federal law.

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

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

Genetic Counseling - counseling by a qualified clinician that includes:

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

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

[Applies to plan offer OFF the Exchange]

[Group - the Small Employer, as defined under Maryland insurance law, to whom the Policy is issued.]

[Applies to SHOP plans only.]

[Group - a small employer that, during the preceding calendar year, did not employ an average of more than 50 employees. If the small employer did not exist in the preceding calendar year, the number of employees will be based on the average number of employees the small employer is reasonably expected to employ on business days in the current calendar year. In this instance, if the small employer increases the number of employees to over 50, the employer will continue to be treated as a small employer as long as it continuously makes enrollment through the SHOP Exchange available to its employees. The small employer elects to make its Full-Time Employees eligible for one of more Qualified Health Plans offered through the SHOP Exchange and, at the option of the Group, some or all of its Part-Time Employees, provided that the Group:

- Has its principal place of business in the State and elects to provide coverage through the SHOP Exchange to all its Eligible Employees, wherever employed; or
- Elects to provide coverage through the SHOP Exchange to all of its Eligible Employees who are principally employed in the State.]

Health Care Practitioner - any individual or health care facility licensed or certified, or otherwise authorized under the *Health Occupations Article* to provide health care services.

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

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.

SAMPLE

- 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.

[Applies to all plan designs unless declined by a group that is a bona fide religious organization and the coverage conflicts with the bona fide religious beliefs and practices of that organization.]

[**Iatrogenic Infertility** - an impairment of fertility caused directly or indirectly by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes.]

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.

Initial Enrollment Period - the first period of time when Eligible Persons may enroll themselves and their Dependents under the Policy.

Injury - 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, including treatment in a provider's office, 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 Program(s) - a structured outpatient treatment program.

- For Mental Health Care Services, the program may be freestanding, Hospital-based or in a provider's office 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.

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.

SAMPLE

- 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] 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 Mental Disorders* published by 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 Mental Disorders* published by 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 Delegate - 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 Mental Disorders* published by 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 Mental Disorders* published by the *American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Care Service.

["Shared Savings Program" is bracketed to accommodate possible name change.]

SAMPLE

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 by way of their participation in the [Shared Savings Program] but who have not entered into a full participation agreement to be a Network provider. 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 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.

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.

[Applies to plans offered OFF the Exchange]

[Open Enrollment Period - a period of time that follows the Initial Enrollment Period during which Eligible Persons may enroll themselves and Dependents under the Policy. The Group determines the period of time that is the Open Enrollment Period.]

[Applies for SHOP plans only]

[Open Enrollment Period - a period of time outside of the Initial Enrollment Period and the Annual Open Enrollment Period during which new Eligible Persons may enroll themselves and Dependents under the Policy, as provided and determined by the SHOP Exchange.]

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 enrollees.

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 enrollees.

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)*.

SAMPLE

- 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.

Part-Time Employee - an employee of the Group who:

- Has a normal work week of at least 17.5 hours; and
- Is not a Full-Time Employee.

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. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Policy.

[Applies to plan offered on the Exchange.]

[Plan Year - a consecutive 12 month period during which we provide coverage for Benefits.]

[[1]Applies to plans offered off the Exchange only]

Policy - the entire agreement issued to the Group that includes all of the following:

- *Group Policy*.
- *Certificate*.
- *Schedule of Benefits*.
- [[1]Group *Application*.]
- Riders.
- Amendments.
- Notices of Change.

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

Policy Charge - the sum of the Premiums for all Covered Persons enrolled under the Policy.

SAMPLE

Pregnancy - includes all of the following:

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

[Applies to all plan designs unless declined by a group that is a bona fide religious organization and the coverage conflicts with the bona fide religious beliefs and practices of that organization.]

[Preimplantation Genetic Testing (PGT) - a test performed to analyze the DNA from oocytes or embryos for human leukocyte antigen (HLA) typing or for determining genetic abnormalities. These include:

- PGT-M - for monogenic disorder (formerly single-gene PGD).
- PGT-SR - for structural rearrangements (formerly chromosomal PGD).]

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

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

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

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:

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

[Applies to SHOP plans]

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

Qualifying 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 - with respect to an item or service furnished by an Out-of-Network Provider or Out-of-Network Emergency Facility, an amount that is determined as follows:

- 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 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 *HSCRC*.

SAMPLE

- If there is no such All-Payer Model Agreement applicable to the item or service, in a State that has in effect a specified State law, the amount for the item or service determined in accordance with such specified State law. Under specified Maryland law, for an on-call physician or a hospital-based physician who has obtained an assignment of benefits from the Covered Person, this is the amount required by § 14–205.2 of the *Insurance Article*.
- If neither an All-Payer Model Agreement or a specified State law apply to the item or service, the lesser of:
  - the amount billed by the Out-of-Network Provider or Out-of-Network Emergency Facility,
  - or the Qualifying Payment Amount.

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 care 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.
  - 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 *Certificate*. Covered Health Care Services provided by a Rider may be subject to payment of additional

SAMPLE

Premiums. (Note that Benefits for Pediatric Vision Care Services, Pediatric Dental Services while presented in Rider format, are not subject to payment of additional Premiums and are included in the overall Premium for Benefits under the Policy.) Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended in the Rider.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health 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 we serve, which has been 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.

["Shared Savings Program" is bracketed for possible name change.]

[Shared Savings Program] - a program in which we may obtain a discount to an Out-of-Network Provider's billed charges. This discount is usually based on a schedule previously agreed to by the Out-of-Network Provider and a third-party vendor. If the Out-of-Network Provider agrees to participate in the Shared Savings Program, they must accept the discounted rates. When this happens, you will experience lower out-of-pocket amounts. Co-insurance and any applicable deductible would still apply to the reduced charge. Policy provisions or administrative practices supersede the scheduled rate, and a different rate is determined by us. This means, when permitted by our [Shared Savings Program] contract, we will pay the lesser of the [Shared Savings Program] discount or an amount determined by us, such as a percentage of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market, an amount determined based on available data resources of competitive fees in that geographic area, a fee schedule established by a third party vendor or a negotiated rate with the provider. In this case, the Out-of-Network Provider may bill you for the difference between the billed amount and the rate determined by us. If this happens, you should call the telephone number shown on your ID card for assistance with resolving the issue. [Shared Savings Program] providers are not Network providers and are not credentialed by us.

[Applies to SHOP plans]

[SHOP Exchange - the Small Business Health Options Program Exchange operated in the state of issuance of the Policy.]

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this *Certificate* includes Mental Illness or substance-related and addictive disorders.

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:

SAMPLE

- 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.

Small Employer - an employer that, during the preceding calendar year, employed an average of not more than 50 employees.

For the purpose of this definition:

- All persons treated as a single employer under § 414(b), (c) or (o) of the Internal Revenue Code shall be treated as a single employer;
- An employer and any predecessor employer shall be treated as a single employer;
- The number of employees of an employer shall be determined by adding:
  - The number of Full-Time Employees; and
  - The number of full-time equivalent employees, which shall be calculated for a particular month by dividing the aggregate number of hours of service of employees who are not full-time employees for the month by 120.
- If an employer was not in existence throughout the preceding calendar year, the determination of whether the employer is a small employer shall be based on the average number of employees that the employer is reasonably expected to employ on business days in the current calendar year[.][;] [and]

[Applies to SHOP plans only.]

- [An employer that makes enrollment in Qualified Health Plans available to its employees through the SHOP Exchange, and would cease to be a small employer by reason of an increase in the number of its employees, shall continue to be treated as a small employer as long as it continuously makes enrollment through the SHOP Exchange available to its employees; and]

To the extent permitted by federal law, an entity that leases employees from a professional employer organization, co-employer, or other organization engaged in employee leasing and that otherwise meets the description in this definition shall be treated as a small employer.

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

Specialty Pharmaceutical Product - Pharmaceutical Products that:

- are prescribed for an individual with a complex or chronic medical condition or a rare medical condition;
- costs $600 or more for up to a 30-day supply;
- are 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 Pharmaceutical Products do not include drugs prescribed to treat diabetes, HIV or AIDS.

You may access a complete list of Specialty Pharmaceutical Products through the Internet at [www.myuhc.com] or by calling us at the telephone number on your ID card.

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

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 Mental Disorders* published by 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 Mental Disorders* published by the *American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Care Service.

To Stabilize - with respect to an emergency medical condition, 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.

Total Disability or Totally Disabled - a Subscriber's inability to perform all of the substantial and material duties of his or her regular employment or occupation; and a Dependent's inability to perform the normal activities of a person of like age and sex.

Treating Provider - a Physician or Other Health Care Provider who has evaluated the individual.

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 or behavioral health condition or not determined to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-designed randomized controlled trials or observational studies in the prevailing published peer-reviewed medical literature.

- Well-designed systematic reviews (with or without meta-analyses) of multiple well-designed randomized controlled trials.
- Individual well-designed randomized controlled trials.
- Well-designed observational studies with one or more concurrent comparison group(s) including cohort studies, case-control studies, cross-sectional studies, and systematic reviews (with or without meta-analyses) of such studies.

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] [and] [liveandworkwell.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 Center - an entity 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.

Visit - means 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.

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Section 10: Prescription Drug Products

Coverage Policies and Guidelines

Our Prescription Drug List (PDL) Management Committee makes tier placement changes on our behalf. The PDL Management Committee places FDA-approved Prescription Drug Product into tiers by considering a number of factors including clinical and economic factors. 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.

We may, from time to time, change the placement of a Prescription Drug Product among the tiers. These changes generally will happen quarterly, but no more than six times per calendar year. If a drug is removed from the PDL or moved to a higher tier, notice will be provided at least 30 days prior to this change and a review for medically necessity will be allowed prior to the change becoming effective. See *Section 6: Questions, Complaints and Appeals* if there is an adverse decision. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please contact us at [www.myuhc.com] 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 PDL Management Committee 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 Physician.

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 may seek reimbursement from us as described in the *Certificate* 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, Ancillary Charge and any deductible that applies.

Submit your claim to:

Optum Rx

PO Box 650629

Dallas, TX 75265-0629

Designated Pharmacies

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

If you are directed to a Designated Pharmacy and do not to obtain your Specialty Prescription Drug Product from a Designated Pharmacy, you will be subject to the out-of-Network Benefit for that Specialty Prescription Drug Product. This requirement does not apply to oncologist-administered specialty drugs.

If you choose to obtain Specialty Prescription Drug Products that are available from a Non-Preferred Specialty Network Pharmacy, you will be subject to the Non-Preferred Specialty Network Pharmacy Co-payment and/or Co-insurance.

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When Do We Limit Selection of Pharmacies?

If we determine that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your choice of Network Pharmacies may be limited. If this happens, we may 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.

Rebates and Other Payments

We may receive rebates for certain drugs included on the Prescription Drug List, including those drugs that you purchase prior to meeting any applicable deductible. A portion or all these rebates will be applied to the calculation of your member cost share at the point-of-sale, resulting in either the same or lower cost share than you otherwise would pay.

We, and a number of our affiliated entities, conduct business with pharmaceutical manufacturers separate and apart from this Certificate. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this Certificate. We are not required to pass on to you, and do not pass on to you, such amounts.

Special Programs

We offer programs in which you can receive an enhanced Benefit based on your plan or 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] or the telephone number on your ID card. The following are current Special Programs:

- The My ScriptRewards program is designed to provide you a financial benefit for switching from a qualifying higher-tiered Specialty Prescription Drug Product to a qualifying lower-tiered Specialty Prescription Drug Product. You can receive a $250 reward when you switch and fill your first prescription for a qualifying lower-tiered Specialty Prescription Drug Product. You can continue to receive a $250 reward every six months if you continue to fill the qualifying lower-tiered Specialty Drug Product, up to a maximum of $500 annually. Rewards are provided on a prepaid debit card for qualifying medical expenses. To find out which medications are currently included in the program, please contact us at [www.myuhc.com] or the telephone number on your ID card.
- The Sempre Health program is designed to help you with medication adherence for qualifying Prescription Drug Products. If you enroll in the program, your cost sharing is reduced when you refill a qualifying Prescription Drug Product as prescribed. You will be sent enrollment materials if you are eligible for the program. To find out which medications are currently included in the program, please contact us at [www.myuhc.com] or the telephone number on your ID card.

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 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 *Schedule of Benefits* for applicable Co-payments and/or Co-insurance requirements.

[Include if the plan has an Annual Drug Deductible]

We will apply any discount, financial assistance payment, product voucher, or other out-of-pocket expense made on your behalf for Prescription Drug Products toward your Co-insurance, Co-payment, Annual Deductible, [Annual Drug Deductible,] or Out-of-Pocket Limit. If you have a Health Savings Account (HSA)-compatible high-deductible health plan, application of any third-party payment will occur after you meet your Annual Deductible.

[Remove contraception language for a bona fide religious organization that opts out because the coverage conflicts with the bona fide religious beliefs and practices of that organization.]

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Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Care Service [or is prescribed to prevent conception].

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

If you require Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Specialty Prescription Drug Products. Please see *Designated Pharmacies* above. This requirement does not apply to oncologist-administered specialty drugs.

Please see *Defined Terms* below for a full description of Specialty Prescription Drug Product and Designated Pharmacy.

The *Schedule of Benefits* will tell you how Specialty Prescription Drug Product supply limits apply.

Prescription Drugs for Smoking Cessation

In accordance with state law, we provide Benefits for Prescription Drug Products when prescribed by an Authorized Prescriber for:

- Any Prescription Drug Product that is approved by the *U.S. Food and Drug Administration (FDA)* as an aid for the cessation of the use of tobacco products; and

[[1]Select calendar or policy based on the plan selected by the Group.]

- Any Prescription Drug Product defined as Nicotine Replacement Therapy limited to two 90-day courses of treatment per [[1]calendar] [[1]Policy] year.

Prescription Eye Drop Medication

When a Prescription Drug Product is a covered prescription eye drop medication, Benefits will be provided for early eye drop refills, in accordance with guidance for early refill of topical ophthalmic product provided to Medicare Part D plan sponsors by the *Centers for Medicare and Medicaid*; and if: 1) the prescribing Physician indicates on the original Prescription Order or Refill that additional quantities of the prescription eye drops are needed and; 2) the refill requested by the Covered Person does not exceed the number of additional quantities indicated on the original prescription order or refill.

[Remove prescription contraceptives language for a bona fide religious organization that opts out because the coverage conflicts with the bona fide religious beliefs and practices of that organization.]

[Prescription Contraceptives

Coverage is provided for contraceptive drugs and devices, with or without a prescription. Benefits include all FDA-approved contraceptive methods without cost sharing. We will provide coverage for a single dispensing of a 12-month supply of prescription contraceptives.]

Partial Supply of a Prescription Drug Product

We will allow and apply a pro-rated daily Co-payment or Co-insurance amount based on the number of days' supply dispensed for a partial supply of a Prescription Drug Product that is 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 3 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

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- 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 Drugs from a Retail Network Pharmacy

Benefits are provided for Prescription Drug Products dispensed by a retail Network Pharmacy.

The *Schedule of Benefits* will tell you how retail Network Pharmacy supply limits apply.

Depending upon your plan design, your prescription drug coverage 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].

Prescription Drug Products from a Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy.

The *Schedule of Benefits* will tell you how mail order Network Pharmacy and Preferred 90 Day Retail Network Pharmacy supply limits apply.

Please contact us at [www.myuhc.com] 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 or Preferred 90 Day Retail Network Pharmacy.

Exclusions

In addition to the exclusions listed in *Section 2. Exclusions and Limitations*, the exclusions listed below apply.

When an exclusion applies to only certain Prescription Drug Products, you can contact us at [www.myuhc.com] or the telephone number on your ID card for information on which Prescription Drug Products are excluded.

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit, except for what is provided above under the heading *Partial Supply of a Prescription Drug Product.*
3. Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
4. Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
5. 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 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.
6. Prescription Drug Products furnished by the local, state or federal government. This exclusion does not apply services provided or rendered under state medical assistance.
7. 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

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or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.

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

9. A Pharmaceutical Product for which Benefits are provided *under Section 1: Covered Health Care Services, Pharmaceutical Products - Outpatient* in this *Certificate*. This includes certain forms of vaccines/immunizations.

10. Durable Medical Equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your Certificate. Prescribed and non-prescribed outpatient supplies. This does not apply to covered insulin pumps and related supplies that are distributed exclusively through pharmacy channels, diabetic supplies and inhaler spacers specifically stated as covered.

11. General vitamins, except the following, which require a Prescription Order or Refill:
    - Prenatal vitamins.
    - Vitamins with fluoride.
    - Single entity vitamins.

12. Prescription Drug Products that are packaged in such a way that one package contains a single dose of medication. Exceptions to this exclusion are made if a Prescription Drug Product is available only in single dose packaging (i.e., unit dose). Prescription Drug Products which have been removed from its original manufacturer container and placed into a different container without any manipulation (i.e., repackaged).

13. Prescription Drug Products used solely for cosmetic or convenience 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.

[Exclusion only applies for a bona fide religious organization that opts out because the coverage conflicts with the bona fide religious beliefs and practices of that organization.]

[16.] [Prescription Drug Products when prescribed to treat infertility.]

[Exclusion only applies for a bona fide religious organization that opts out because the coverage conflicts with the bona fide religious beliefs and practices of that organization.]

[17.] [Prescription Drug Products when prescribed to prevent conception. This includes, but is not limited to, oral contraceptives, diaphragms, Depo Provera and other injectable drugs used for contraception.]

[Include for groups that object to emergency contraceptives based on a statutory or regulatory exemption.]

[18.] [Prescription Drug Products that are emergency contraceptives.]

[19.] Certain Prescription Drug Products for tobacco cessation that exceed the minimum number of drugs required to be covered under the *Patient Protection and Affordable Care Act (PPACA)* in order to comply with essential health benefits requirements. This exclusion does not apply to over-the-counter drugs used for tobacco cessation for which Benefits are provided as required under the *PPACA*.

[Applies for plan designs with the Essential or other closed PDL.]

[20.] [Prescription Drug Products not placed on Tier 1 [,] [or] [Tier 2] [,] [or] [Tier 3] [or] [Tier 4] of the Prescription Drug List at the time the Prescription Order or Refill is dispensed. We have developed a process for reviewing Benefits for a Prescription Drug Product that is not on an available tier of

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the Prescription Drug List, but that has been prescribed as a Medically Necessary alternative. For information about this process, call the telephone number on your ID card.]

[21.] 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. Identified compounded drugs that contain a bulk drug substance that fails to qualify for exemption from Sections 501(a)(2)(B), 502(f)(1), and 505 of the *Federal Food, Drug, and Cosmetic Act*, in accordance with 21 U.S.C. §§ 353a and 353b and associated guidance published by the *FDA*. Compounded drugs that are available as a similar commercially available Prescription Drug Product unless the prescribing Physician determines that:

- There is no equivalent Prescription Drug Product.
- The covered equivalent Prescription Drug Product:
  - Has been ineffective in treating the disease or condition of the Covered Person; or
  - Has caused or is likely to cause an adverse reaction or harm to the Covered Person.

Covered compounded drugs are assigned to Tier 3.

[Include unless contraceptives coverage is declined by a bona fide religious organization and the coverage conflicts with the bona fide religious beliefs and practices of that organization.]

[22.] The following over-the-counter drugs and products:

- Drugs or products 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 drug or product 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. This exclusion does not apply *FDA* approved over-the-counter medications that are considered *ACA* preventive medications. [This exclusion also does not apply to *FDA* approved contraceptive drugs that are available over-the counter and do not require a prescription.]
  - Over-the-counter continuous glucose monitors; and

  The following Prescription Drug Products with over-the-counter alternatives;

  - 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. Such determinations may be made up to six times during a calendar year.
  - Certain Prescription Drug Products that we have determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year.

  We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

  We will provide coverage for excluded Prescription Drug Products described above if, in the judgment of the Authorized Prescriber:

  - the over-the-counter drug is not equivalent to the Prescription Drug Product on the Prescription Drug List; or
  - an equivalent over-the-counter drug:
    - has been ineffective in treating a Covered Person's disease or condition; or
    - has caused or is likely to cause an adverse reaction or other harm to the Covered Person.

[23.] Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by our PDL Management Committee. We will provide immediate coverage for a New Prescription Drug Product if, in the judgment of the Authorized Prescriber:

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- There is no equivalent Prescription Drug Product on the Prescription Drug List; or
- An equivalent Prescription Drug Product on the Prescription Drug List:
  - Has been ineffective in treating a Covered Person's disease or condition; or
  - Has caused or is likely to cause an adverse reaction or other harm to the Covered Person.

[24.] 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 described under *Medical Foods and Mental Health Care and Substance-Related and Addictive Disorders Services* of *Section 1: Covered Health Care Services*.

[25.] A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product or Pharmaceutical Product as described in *Section 1: Covered Health Care Services*. Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision. Please access [www.myuhc.com] through the Internet or call us at the telephone number on your ID card for information on which Prescription Drug Products classified as Therapeutic Equivalent.

Note: We will provide immediate coverage for a Prescription Drug Product deemed Therapeutically Equivalent if, in the judgment of the Authorized Prescriber:

- The excluded Prescription Drug Product is not Therapeutically Equivalent to the other covered Prescription Drug Product; or
- The covered Prescription Drug Product on the Prescription Drug List:
  - Has been ineffective in treating a Covered Person's disease or condition; or
  - Has caused or is likely to cause an adverse reaction or other harm to the Covered Person.

[26.] 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 or Pharmaceutical Product as described in *Section 1: Covered Health Care Services*. Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision. Please access [www.myuhc.com] through the Internet or call us at the telephone number on your ID card for information on which Prescription Drug Products classified as Therapeutic Equivalent.

Note: We will provide immediate coverage for a Prescription Drug Product deemed Therapeutically Equivalent if, in the judgment of the Authorized Prescriber:

- The excluded Prescription Drug Product is not Therapeutically Equivalent to the other covered Prescription Drug Product; or
- The covered Prescription Drug Product on the Prescription Drug List:
  - Has been ineffective in treating a Covered Person's disease or condition; or
  - Has caused or is likely to cause an adverse reaction or other harm to the Covered Person.

[27.] Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives to another Prescription Drug Product or Pharmaceutical Product as described in *Section 1: Covered Health Care Services* available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision. We will provide immediate coverage for Therapeutically Equivalent alternatives if, in the judgment of the authorized prescriber (as defined in *Section 12-101* of the *Health Occupation Article of the Maryland Code)*:

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- The excluded Therapeutically Equivalent alternatives are not therapeutically equivalent to the other covered Pharmaceutical Products; or
- The covered Therapeutically Equivalent alternatives on the Pharmaceutical Product List:
  - Has been ineffective in treating a Covered Person's disease or condition; or
  - Has caused or is likely to cause an adverse reaction or other harm to the Covered Person.

[28.] A Prescription Drug Product that contains marijuana, including medical marijuana.

[29.] Certain Prescription Drug Products that exceed the minimum number of drugs required to be covered under the *Patient Protection and Affordable Care Act (PPACA)* essential health benefit requirements in the applicable United States Pharmacopeia category and class or applicable state benchmark plan category and class.

[30.] Dental products, including but not limited to prescription fluoride topicals. This exclusion does not apply to preventive prescription oral fluoride supplements for children.

[31.] A Prescription Drug Product with either:

- An approved biosimilar.
- A biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product or Pharmaceutical Product as described in *Section 1: Covered Health Care Services*.

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).
- It has no clinically meaningful differences in terms of safety and effectiveness from the reference product.

Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

[32.] Diagnostic kits and products, including associated services. This exclusion includes products/agents used to help diagnose a condition. These may be covered through the medical benefit. Examples include barium, drug assay test kits, DNA collection kits, and urine collection kits.

[33.] Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.

[34.] 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, for convenience. This exclusion only applies to Prescription Drug Products that have covered Therapeutic Equivalents. This exclusion does not apply to a device or application that assists you with the administration of a Prescription Drug Product.

[35.] Prescription Drug Products prescribed by a provider who is on our list of excluded providers due to fraud, waste, and/or abuse findings.

When a Prescription Drug Product is excluded from coverage, 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 receipt of the request.

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Defined Terms

Ancillary Charge - a charge, in addition to the Co-payment and/or Co-insurance, that you must pay when a covered Prescription Drug Product is dispensed at your or the provider's request, when a Chemically Equivalent Prescription Drug Product is available.

For Prescription Drug Products from Network Pharmacies, the Ancillary Charge is the difference between:

- The Prescription Drug Charge for the Prescription Drug Product.
- The Prescription Drug Charge for the Chemically Equivalent Prescription Drug Product.

For Prescription Drug Products from out-of-Network Pharmacies, the Ancillary Charge is the difference between:

- The Out-of-Network Reimbursement Rate for the Prescription Drug Product.
- The Out-of-Network Reimbursement Rate for the Chemically Equivalent Prescription Drug Product.

[Include if the plan has an Annual Drug Deductible]

[**Annual Drug Deductible** - the amount you must incur for covered [[Tier 2] [,] [and] [Tier 3] [,] [and] [Tier 4]] Prescription Drug Products in a year before we begin paying for Prescription Drug Products. The *Schedule of Benefits* will tell you how the Annual Drug Deductible applies.]

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

Brand-name - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that we identify as a Brand-name product, based on available data resources. 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.

Complex or Chronic Medical Condition - a physical, behavioral or developmental 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.

Chemically Equivalent - when Prescription Drug Products contain the same active ingredient.

Designated Pharmacy - a pharmacy that has entered into an agreement with us or with an organization contracting on our behalf, to provide specific Prescription Drug Products. This includes 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.

List of Preventive Medications - a list that identifies certain Prescription Drug Products, which may include certain Specialty Prescription Drug Products, on the Prescription Drug List that are intended to reduce the likelihood of Sickness. You may find the List of Preventive Medications by contacting us at [www.myuhc.com] or the telephone number on your ID card.

List of Zero Cost Share Medications - a list that identifies certain Prescription Drug Products on the Prescription Drug List that are available at zero cost share (no cost to you) when obtained from a retail Network Pharmacy. Certain Prescription Drug Products on the List of Zero Cost Share Medications may be available at a mail order Network Pharmacy. You may find the List of Zero Cost Share Medications by contacting us at [www.myuhc.com] or the telephone number on your ID card.

Maintenance Medication - a Prescription Drug Product expected to be used for six months or more to treat or prevent a chronic condition. You may find out if a Prescription Drug Product is a Maintenance Medication by contacting us at [www.myuhc.com] or the telephone number on your ID card.

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Network Pharmacy - a pharmacy that has:

- Entered into an agreement with us or an organization contracting on our behalf to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by us as a Network Pharmacy.

New Prescription Drug Product - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

- The date it is placed on a tier by our PDL Management Committee.
- December 31st of the following calendar year.

Non-Preferred Specialty Network Pharmacy - a specialty pharmacy that we identify as a non-preferred pharmacy within the Network.

Out-of-Network Reimbursement Rate - the Allowed Amount we will pay for a Prescription Drug Product that is dispensed at an out-of-Network Pharmacy. The Out-of-Network Reimbursement Rate for a particular Prescription Drug Product dispensed at an out-of-Network Pharmacy includes a dispensing fee and any applicable sales tax.

PPACA - Patient Protection and Affordable Care Act of 2010.

PPACA Zero Cost Share Preventive Care Medications - the medications 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, Annual Deductible, Annual Drug 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*.
- Certain 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*.

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] or the telephone number on your ID card.

Preferred 90 Day Retail Network Pharmacy - a retail pharmacy that we identify as a preferred pharmacy within the Network for Maintenance Medication.

Preferred Specialty Network Pharmacy - a specialty pharmacy that we identify as a preferred pharmacy within the Network.

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 - 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

SAMPLE

Prescription Drug Product has been placed by contacting us at [www.myuhc.com] or the telephone number on your ID card.

Prescription Drug List (PDL) Management Committee - the committee that we designate for placing Prescription Drug Products into specific tiers.

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 generally 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.
- Certain vaccines/immunizations administered at a Network Pharmacy.
- Certain injectable medications administered at a Network Pharmacy.
- Tobacco cessation prescription drugs.
- The following diabetic supplies:
  - standard insulin syringes with needles;
  - blood-testing strips - glucose;
  - urine-testing strips - glucose;
  - ketone-testing strips and tablets;
  - lancets and lancet devices; and
  - glucose meters, including 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.

[[1]Applies if coverage in superscript 2 is not included. [2]Applies to all plan designs unless declined by a group that is a bona fide religious organization and the coverage conflicts with the bona fide religious beliefs and practices of that organization.]

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;
- costs $600 or more for up to a 30-day supply;
- are 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 may include drugs on the List of Preventive Medications[[1].][[2]and Specialty Prescription Drug Products for fertility preservation and Preimplantation Genetic Testing (PGT) for which Benefits are described in the Certificate under *Fertility Preservation for Iatrogenic Infertility and Preimplantation Genetic Testing (PGT) and Related Services* under *Section 1: Covered Health Care*

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Services.] Specialty Prescription Drug Products do not include drugs prescribed to treat diabetes, HIV or AIDS.

Therapeutically Equivalent - when Prescription Drug Products or Pharmaceutical Product as described in *Section 1: Covered Health Care Services* 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 to the pharmacy by third parties. This fee includes any applicable dispensing fee and sales tax.

Your Right to Request an Exclusion Exception

When a Prescription Drug Product is excluded from coverage, 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 and your representative of our determination within 72 hours.

Please note, if your request for an exception is approved by us, you may be responsible for paying, in addition to any applicable Ancillary Charge, the higher of:

- The applicable Co-payment and/or Co-insurance at the highest tier as described in the *Schedule of Benefits*, or
- A Co-insurance of 50%.

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 should 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 exclusion exception request, you or your representative may be entitled to request an external review. You or your representative may 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 its determination within 72 hours of receipt of the request.

Expedited External Review

If you are not satisfied with our determination of your exclusion exception request and it involves an urgent situation, you or your representative may 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 its determination within 24 hours following receipt of the request.

If you need additional information regarding the prescription drug exception process you may contact us by calling the toll-free number on your ID card.

[Always include unless declined by a group that is a bona fide religious organization and the coverage conflicts with the bona fide religious beliefs and practices of that organization.]

[Your Right to Request an Exception for Contraceptives

In accordance with PPACA requirements, an exception process may apply to certain Prescription Drug Products prescribed for contraception if your Physician determines that a Prescription Drug Product alternative to a PPACA Zero Cost Share Preventive Care Medication is Medically Necessary for you.

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An expedited medication exception request may be available if the time needed to complete a standard exception request could significantly increase the risk to your health or ability to regain maximum function.

If a request for an exception is approved by us, Benefits provided for the Prescription Drug Product will be treated the same as a PPACA Zero Cost Share Preventive Care Medication.

[Source path variable for future changes.]

For more information please visit [www.uhcprovider.com] under the following path: [*Resources_Drug Lists and Pharmacy_Additional Resources_Patient Protection and Affordable Care Act $0 Cost-Share Preventive Medications Exemption Requests (Commercial Members)*].]

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UnitedHealthcare Choice

MAMSI Life and Health Insurance Company

Schedule of Benefits

UHC Choice HSA Gold 2000-2

How Do You Access Benefits?

You must see a Network Physician in order to obtain Benefits. 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.

Benefits apply to Covered Health Care Services that are provided by a Network Physician or other Network provider. You are not required to select a Primary Care Physician in order to obtain Benefits.

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*.

Designated Network Benefits apply to Covered Health Care Services that are provided by a provider or facility that has been identified as a Designated Provider. Designated Network Benefits are available only for specific Covered Health Care Services as shown in the *Schedule of Benefits* table below.

Depending on the geographic area and the service you receive, you may have access through our Shared Savings Program to Out-of-Network Providers who have agreed to discount their billed charges for Covered Health Care Services. Refer to the definition of Shared Savings Program in *Section 9: Defined Terms* of the *Certificate* for details about how the Shared Savings Program applies.

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under a UnitedHealthcare Policy. As a result, they may bill you for the entire cost of the services you receive.

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 by the Group, this *Schedule of Benefits* will control.

Does Prior Authorization Apply?

We require prior authorization for certain Covered Health Care Services, including certain Prescription Drug Products. Network providers are responsible for obtaining prior authorization before they provide these services to you.

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We recommend that you confirm with us that all Covered Health Care Services have been prior authorized as required. Before receiving these services from a Network provider, you may want to call us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they do not prior authorize as required. You can call us at the telephone number on your ID card.

Note: We will not require prior authorization for a contraceptive drug or device that is:

- An intrauterine device; or
- An implantable rod;
- Approved by the FDA; and
- Obtained under a prescription written by an authorized prescriber.

However, for a contraceptive drug or device for which the *U.S. Food and Drug Administration* has issued a black box warning, we may require a prior authorization, to the extent that state law allows.

If a Covered Service requires prior authorization and it is provided, it will be for a course of treatment, including for chronic conditions, rehabilitative services, substance use disorders, and mental health conditions, that is:

- for a period of time that is as long as necessary to avoid disruptions in care; and
- determined in accordance with applicable coverage criteria, the Covered Person's medical history, and the health care provider's recommendation.

For a new Covered Person, we will not request re-authorization for an active course of treatment for Covered Services for at least 90 days after the date of enrollment.

Prior Authorization for Prescription Drug Products Used to Treat Chronic Conditions

If a Prescription Drug Product requires prior authorization, the health care provider can indicate whether the Prescription Drug Product is to be used to treat a chronic condition. If we approve the prior authorization request, we will not request re-authorization for the Prescription Drug Product for one year after the approval or for the standard course of treatment for the chronic condition being treated, whichever is less.

Additionally, if we approve a prior authorization request for an immune globulin (human) as defined in 21 CFR §640.100 or a prescription drug used for the treatment of a mental disorder listed in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* published by the *American Psychiatric Association,* we will not deny reauthorization or request additional documentation from the prescriber for a reauthorization request if the Covered Person has been treated with the Prescription Drug Product without interruption since the initial approval of the prior authorization, and the prescriber attests that, based on the prescriber's professional judgment, the Prescription Drug Product continues to be necessary to effectively treat the Covered Person's condition.

Multiple Prior Authorizations of the Same Prescription Drug Product

We will not require more than one prior authorization if two or more tablets of different dosage strengths of the same Prescription Drug Product are:

- Prescribed at the same time as part of a treatment plan; and
- Manufactured by the same manufacturer.

An additional prior authorization is allowed for two or more tablets of different dosage strengths of an opioid that is not an opioid partial agonist.

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Prior Authorization for Prescription Drug Products from a Previous Plan Issued by Us

If you received prior authorization for a Prescription Drug Product from us prior to changing plans issued by us, we will honor that authorization for at least the lesser of 90 days or the length of the course of treatment and will not require your health care provider to submit another prior authorization for the Prescription Drug Product:

- If you have changed health benefit plans that are both covered by us and the Prescription Drug Product is a covered benefit under your new plan; or
- When the dosage for the previously approved Prescription Drug Product changes and the change is consistent with the *Federal Food and Drug Administration* labeled dosages. This does not apply when the change in dosage is for an opioid.

Utilization Review Determinations

For any Benefit for which utilization review applies, the following standards will apply.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include, but are not limited to, ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review.

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

A private review agent will make all utilization review decisions. Providers are promptly notified of all utilization review decisions. A private review agent will be available 24 hours a day, 7 days a week.

Initial utilization review Benefit determinations on whether to authorize or certify a non-emergency course of treatment or health service, including pharmaceutical services not submitted electronically, will be made within two (2) working days after receipt of information necessary to make the determination.

A step therapy exception request submitted electronically will be approved in real time if:

- no additional information is needed to process the request, and
- the request meets the criteria for approval, or
- If a request is not approved in real time, within one (1) working day after receipt of all information necessary to make the determination.

Utilization review determinations to authorize or certify an extended stay in a health care facility, additional health care services, or a request for additional visits or days or care submitted as part of an existing course of treatment or treatment plan will be made within one (1) working day after receipt of information necessary to make the determination. We will promptly notify your health care provider regarding the determination.

After the receipt of the initial request, and confirming through a complete review of information already submitted by the provider, if additional information is required to make a determination, your provider will be promptly, but not later than three calendar days after receipt of the initial request, notified that additional information is required by specifying:

- The information, including any lab or diagnostic test or other medical information, that must be submitted to complete the request, and
- The criteria and standards to support the need for additional information.

When prior authorization is required for inpatient or Residential Crisis Services for the treatment of Mental Health Care and Substance-Related and Addictive Disorders, determinations on whether or not to authorize or certify such services will be made within 2 hours after receipt of necessary information. If additional information is needed, your provider will be promptly requested to provide the specific

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information needed, including any lab or diagnostic test or other medical information. Your provider will be promptly notified of the decision.

Prior authorization is not required for Emergency Health Care Services.

If the initial determination is not to authorize or certify services and the provider believes the decision warrants reconsideration, the provider will be provided the opportunity to speak with the Physician who rendered the decision. Such discussion and decision will take place by telephone on an expedited basis within 24 hours of the request for reconsideration. If the Physician is unable to immediately speak with the health care provider seeking the reconsideration, the health care provider will be provided a direct telephone number that is not the general customer call number or a monitored e-mail address that is dedicated to communication related to utilization review.

Adverse decisions for emergency inpatient admissions may not be made solely because the Hospital did not notify within 24 hours of admission or other time period after admission because the patient's medical condition prohibited determination of: 1) the patient insurance status; and 2) any applicable admission notification requirements.

An adverse determination may not be rendered during the first 24 hours after admission if; a) the admission is based on the patient as an imminent danger to self or others; b) the determination is made by the patient's Physician or psychologist in conjunction with a member of the medical facility who has privileges to make the admission; and c) the Hospital immediately provides notification of the admission and the reasons for admission.

An adverse determination may not be rendered for admission to a Hospital for up to 72 hours, as determined to be Medically Necessary by the patient's treating physician when; a) the admission is an involuntary admission as described under Maryland insurance law and; b) the Hospital immediately provides notification of the admission and the reasons for admission.

If the provider is required to submit a treatment plan in order for utilization review to be conducted for Mental Health Care and Substance-Related and Addictive Disorders Services, the uniform treatment plan as provided under Maryland insurance law will be accepted or, if service was provided in another state, a treatment plan mandated by that state. Such treatment plan must be properly completed by the provider and may be submitted by electronic transfer.

If a private review agent fails to make a determination within the time limits noted in this provision, the request shall be deemed approved.

Patient Centered Medical Homes

Benefits include delivery of Benefits through patient centered medical homes for Covered Persons with chronic conditions, serious illnesses or complex health care needs who agree to participate in a patient centered medical home program. This includes associated costs for coordination of care such as:

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

Your Right to a Second Opinion with Regard to Hospital Utilization Review Decisions

The State of Maryland requires all acute general hospitals to maintain a stringent utilization review process. This means that certain items such as elective inpatient hospital admissions, certain inpatient

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surgical procedures and length of inpatient stay may be subject to review or pre-authorization by the hospital in addition to any such review or pre-authorization requirement under the terms of this Policy.

If the hospital's utilization review results in denial of inpatient services, we will pay the cost of a corresponding outpatient service. If the hospital's utilization review requires a second opinion, we will cover all reasonable expenses in connection with the second opinion in full with no Co-payment, Co-insurance, or deductible.

When Are Benefits Available for Prescription Drug Products?

Benefits are available for Prescription Drug Products at either a Network Pharmacy or an out-of-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 or is prescribed to prevent conception.

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 may change. Therefore your Co-payment and/or Co-insurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product. If the change involves the removal of a Prescription Drug Product or to a higher cost-sharing tier, we will provide you with 30 days' written notice before it becomes effective. We will provide immediate coverage for a Brand-name Prescription Drug Product, at the previous cost-sharing tier, if in the judgment of the Authorized Prescriber:

- The Generic Prescription Drug Product is not equivalent to the Brand-name Prescription Drug Product; or
- The covered Generic Prescription Drug Product on the Prescription Drug List:
  - Has been ineffective in treating a Covered Person's disease or condition; or
  - Has caused or is likely to cause an adverse reaction or other harm to the Covered Person.
- For a contraceptive prescription drug or device, the prescription drug or device that is not on the formulary is Medically Necessary for the Covered Person to adhere to the appropriate use of the prescription drug or device.

What Happens When a Biosimilar Product Becomes Available for a Reference Product?

If a biosimilar becomes available for a reference product (a biological Prescription Drug Product), the tier placement of the reference product may change. Therefore, your Co-payment and/or Co-insurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular reference product. If the change involves the removal of a reference product or to a higher cost-sharing tier, we will provide you with 30 days' written notice before it becomes effective. We will provide coverage for a reference product, at the previous cost-sharing tier, if:

- The covered biosimilar product on the Prescription Drug List:
  - Is in a higher tier; or
  - Has been ineffective in treating a Covered Person's disease or condition; or
  - Has caused or is likely to cause an adverse reaction or other harm to the Covered Person.

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How Do Supply Limits Apply?

The following supply limits apply:

- As written by the provider, up to a consecutive 30-day supply of a Prescription Drug Product, including a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.
- When a Prescription Drug Product, including a Specialty Prescription Drug Product, is classified as a Maintenance Medication according to Maryland law and as written by the provider:
  - Up to a consecutive 30-day supply for a new prescription or a change in prescription of a Prescription Drug Product/ Specialty Prescription Drug Product; and
  - Thereafter, up to a consecutive 90-day supply of a Prescription Drug Product/ Specialty Prescription Drug Product subject to a Co-payment and/or Co-insurance up to 2 times the Co-payment and/or Co-insurance for a 30-day supply.
- When a Prescription Drug Product/ Specialty Prescription Drug Product is a covered prescription eye drop medication, Benefits will be provided for early eye drop refills, in accordance with guidance for early refill of topical ophthalmic product provided to Medicare Part D plan sponsors by the Centers for Medicare and Medicaid; and if: 1) the prescribing Physician indicates on the original Prescription Order or Refill that additional quantities of the prescription eye drops are needed and; 2) the refill requested by the Covered Person does not exceed the number of additional quantities indicated on the original Prescription Order or Refill.
- When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 30-day supply or is classified as a Maintenance Medication, the Co-payment and/or Co-insurance that applies will reflect the number of days dispensed or days the drug will be delivered. However, you will not pay more than $150 per 30-day supply for a Specialty Prescription Drug Product Prescription Order or Refill, no matter how long this supply actually lasts.
- We will provide coverage for a single dispensing of a 12-month supply of prescription contraceptives.
- When a Prescription Drug Product used to treat diabetes, HIV or AIDS is packaged or designed to deliver in a manner that provides more than a consecutive 30-day supply, the Co-payment and/or Co-insurance that applies will reflect the number of days dispensed or days the drug will be delivered. However, you will not pay a Co-payment or Co-insurance more than $150 per 30-day supply for a Prescription Drug Product Prescription Order or Refill, no matter how long this supply actually lasts.

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 may limit the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, (or up to a 90-day supply in a single dispensing of Maintenance Medications when prescribed by an Authorized Prescriber). If the Prescription Order for any Prescription Drug Product (including Maintenance Medications) exceeds the established additional supply limit, you will be charged an additional Co-payment or Co-insurance for the supply that exceeds the limit. However, you will not pay more than a $150 per 30-day supply for Specialty Prescription Drug Products or for a Prescription Drug Product used to treat diabetes, HIV or AIDS, and you will not pay in Co-payments or Co-insurance more than $30 per 30-day supply Prescription Order or Refill for insulin, regardless of the amount or type of insulin needed to fill the prescription. For Prescription Drug Products that allow a 90-day fill, you may be required to obtain a limited number of up to 31-day fills until the maintenance dose is established.

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

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Does Step Therapy Apply?

Certain Prescription Drug Products for which Benefits 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) or Pharmaceutical Product(s) for which Benefits are provided as described under the *Certificate* first.

A step therapy requirement or fail-first protocol 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 disease or 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; or
  - Is being used to treat a symptom of or side effect from treatment of the Covered Person's stage four advanced metastatic cancer; and
  - Use of the prescription drug is consistent with best practices and supported by peer-reviewed medical literature for the treatment of stage 4 advanced metastatic cancer, a condition associated with stage 4 advanced metastatic cancer, or a side effect associated with stage 4 metastatic cancer; or
  - Is insulin or an insulin analog used to treat Type 1, Type 2, or gestational diabetes.

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

Benefits for Oral Chemotherapeutic Agents

Oral chemotherapeutic agent Prescription Drug Products will be provided at a level no less favorable than chemotherapeutic agents are provided under *Pharmaceutical Products – Outpatient* in your *Certificate of Coverage,* regardless of tier placement.

What if a Prescription Drug Product or Device is not in the Formulary?

We will provide coverage for a Prescription Drug Product or device 1.) that is not in our formulary or has been removed from our formulary; or 2.) we will continue to require the same cost sharing requirements if we have moved the Prescription Drug Product or device to a higher deductible, Co-payment or Co-insurance tier if, in the judgment of the Authorized Prescriber:

- There is no equivalent Prescription Drug Product or device in our formulary in a lower tier; or
- An equivalent Prescription Drug Product or device in our formulary in a lower tier:
  - Has been ineffective in treating a Covered Person's disease or condition; or
  - Has caused or is likely to cause an adverse reaction or other harm to the Covered Person; or

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- For a contraceptive Prescription Drug Product or device, the Prescription Drug Product or device that is not on the formulary is Medically Necessary for the Covered Person to adhere to the appropriate use of the Prescription Drug Product or device.

Note: You also have the right to request an exception through the process described under *Your Right to Request an Exclusion Exception* in *Section 10: Prescription Drug Products* of your *Certificate.*

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What Will You Pay for Covered Health Care Services?

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

Annual Deductibles are calculated on a year basis.

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

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

Payment Term And Description	Amounts
Annual Deductible	
The amount you must incur for Covered Health Care Services per year before you are eligible to receive Benefits. The Annual Deductible for benefits includes the amount you incur for outpatient prescription drugs. Benefits for outpatient prescription drugs on the List of Preventive Medications are not subject to payment of the Annual Deductible. Benefits for Prescription Drug Products on the List of Zero Cost Share Medications are not subject to payment of the Annual Deductible unless required by state or federal law. 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. When a Covered Person was previously covered under a group policy that was replaced by the group Policy, any amount already applied to that annual deductible provision of the prior policy will apply to the Annual Deductible provision under the Policy. 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.	***Network*** For single coverage, the Annual Deductible is $2,000. If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is $4,000. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.
Out-of-Pocket Limit	
The maximum you must incur 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 includes the amount you incur for outpatient prescription drug products. 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.	***Network*** For single coverage, the Out-of-Pocket Limit is $4,800. If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Limit stated above does not apply. For family coverage, the family Out-of-Pocket Limit is $9,600.

SAMPLE

Payment Term And Description	Amounts
• Charges that exceed Allowed Amounts, when applicable.	
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. Any dollar amount Co-payment is payable directly to the provider of the Covered Health Care Service at the time of service. If the provider does not request payment of the Co-payment at the time service is rendered or a supply provided, you need not pay the Co-payment at that time, and the provider will bill you for the Co-payment. You will never be denied Covered Health Care Services because of an inability to meet the Co-payment requirement. 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.	
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.	

SAMPLE

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 *Certificate,* 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 Services			
	10%	Yes	Yes
2. Ambulance Services			
In most cases, we will initiate and direct non-Emergency ambulance transportation.			
Emergency Ambulance 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* 10% *Air Ambulance* 10%	Yes Yes	Yes Yes
Non-Emergency Ambulance Ground or Air Ambulance, as we determine appropriate. Allowed Amounts for 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* 10% *Air Ambulance* 10%	Yes Yes	Yes Yes
3. Blood and Blood Products			
	10%	Yes	Yes
4. Case Management 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.*		
5. Cellular Therapy, Gene Therapy, and other			

SAMPLE

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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?**
Genetic/Molecular Therapies			
Cellular Therapy, Gene Therapy, or other genetic/molecular therapy services must be received from a Designated Provider or a Designated Dispensing Entity. Depending upon where the Covered Health Care Service is provided, Benefits for diagnostic services and preservice management will be the same as those stated under each Covered Health Care Service 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*.		
6. Chiropractic Services			
Limited to 20 visits per condition per year	10%	Yes	Yes
7. Controlled 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.*		
8. Dental Services - Accident Only			
	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*.		
9. Dental Services - Hospital and Ambulatory Facility Charges Related to Dental Care			

SAMPLE

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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?**
	Inpatient 10% *Outpatient* 10%	Yes Yes	Yes Yes
10. Detoxification Services			
	Inpatient 10% ***Outpatient Office Visit*** 10% ***Outpatient Other*** *Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Programs* 10% *Intensive Behavioral Therapy* 10% *All Other Outpatient Services such as Electro-Convulsive Treatment, Psychological Testing, Transcranial Magnetic Stimulation, and Medication Assisted Treatment* 10%	Yes Yes Yes Yes Yes Yes	Yes Yes Yes Yes Yes
11. Diabetes Services			
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care	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		

SAMPLE

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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?**
	stated under each Covered Health Care Service category in this *Schedule of Benefits*.		
Diabetes Self-Management Items	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies.* Diabetes test strips are not subject to the Annual Deductible, Co-insurance or Co-payment.		
12. Durable Medical Equipment (DME), Orthotics and Supplies			
You must obtain the DME or orthotic from the vendor we identify or from the prescribing Network Physician.	10%	Yes	Yes
13. Emergency Health Care Services - Outpatient			
Note: If you are admitted, being observed or otherwise receiving treatment 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. The attending emergency Physician or Treating Provider 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 a transfer is medically appropriate, Network Benefits will not be provided. If you are admitted as an inpatient to a Hospital directly from the Emergency room, 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.	10%	Yes	Yes

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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?**
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*. Any applicable deductible or Out-of-Pocket Limit for Emergency Health Care Services received from an Out-of-Network Provider will be applied to any applicable Network deductible or Network Out-of-Pocket Limit.			
14. Family Planning Services			
Male sterilization services not subject to the Co-insurance. See *Prescription Drug Products* for cost sharing for contraceptive Prescription Drug Products.	10%	Yes	Yes
15. Fertility Preservation for Iatrogenic Infertility			
	10%	Yes	Yes
16. Gender Dysphoria			
It is important that you notify us as soon as the possibility of surgery arises. Your notification allows the opportunity for us to provide you with additional information and services that may be available to you and are designed to achieve the best outcomes for you.			
	Depending upon the type of Covered Health Care Service provided, Benefits will be the same as those stated under each		

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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?**
	Covered Health Care Service category in this *Schedule of Benefits*. For example, Mental Health Care Services in the outpatient setting will be subject to that cost share.		
17. 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 10%	Yes	Yes
18. Hearing Aids			
Limited to one hearing aid per hearing impaired ear every 3 years.	10%	Yes	Yes
19. Home Health Care			
To receive Network Benefits 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 *Certificate of Coverage* are not subject to the Annual Deductible, Co-payment or Co-insurance.	10%	Yes	Yes
20. Hospice Care			
	10%	Yes	Yes
21. Hospital - Inpatient Stay			
	10%	Yes	Yes

SAMPLE

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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?**
22. Infertility Services			
	10%	Yes	Yes
23. Lab, X-Ray and Diagnostic - Outpatient			
Lab Testing - Outpatient For Designated Network Benefits, laboratory services must be received from a Designated Diagnostic Provider. Network Benefits include laboratory services received from a Network provider that is not a Designated Diagnostic Provider.	***Designated Network*** 10%	Yes	Yes
	Network 30%	Yes	Yes
X-Ray and Other Diagnostic Testing - Outpatient Diagnostic and supplemental breast examinations are not subject to the Co-insurance.	10%	Yes	Yes
24. Lymphedema 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.*		
25. Major Diagnostic and Imaging - Outpatient			
For Designated Network Benefits, radiology services must be received from a Designated Diagnostic Provider. Network Benefits include radiology services received from a Network	***Designated Network*** 10%	Yes	Yes

SAMPLE

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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?**
provider that is not a Designated Diagnostic Provider.			
	Network 30%	Yes	Yes
26. Medical Foods			
	10%	Yes	Yes
27. Mental Health Care and Substance-Related and Addictive Disorders Services			
	Inpatient 10%	Yes	Yes
	Outpatient Office Visit 10%	Yes	Yes
	Outpatient Other *Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Programs* 10%	Yes	Yes
	Intensive Behavioral Therapy 10%	Yes	Yes
	All Other Outpatient Services such as Electro-Convulsive Treatment, Psychological Testing, Transcranial Magnetic Stimulation, and		

SAMPLE

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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?**
	Medication Assisted Treatment 10%	Yes	Yes
28. Nutritional Services and Medical Nutrition Therapy			
Medically Necessary nutritional counseling and medical nutrition therapy is unlimited.	10%	Yes	Yes
29. Pharmaceutical Products - Outpatient			
	10%, however you will never pay more than $150 per 30-day supply for a Specialty Prescription Drug Product or Pharmaceutical Product to treat diabetes, HIV or AIDS	Yes	Yes
30. 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*.	10%	Yes	Yes
31. Physician's Office Services - Sickness and Injury			
Co-payment/Co-insurance and any deductible for the following services also apply when the Covered Health Care Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and*	10%	Yes	Yes

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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?**
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 under *Therapeutic Treatments - Outpatient*. **Note:** When a test is performed or a sample is drawn in the Physician's office, lab, radiology/X-ray, or other diagnostic analysis or testing whether performed in or out of the Physician's office will apply additional cost sharing as described above.			
32. Pregnancy - Maternity Services			
Abortion care services are covered at no charge once the Annual Deductible is met because your plan is a Health Savings Account (HSA) - compatible high deductible health plan. Once the Annual Deductible is met, the services are not subject to any Co-payment or	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 provided the mother is a Covered Person.		

SAMPLE

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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?**
Co-insurance.			
Doula Services Benefits for certified doula services are limited to services provided within 12 months of diagnosis by a Health Care Practitioner.	None	Yes	No
33. Preimplantation Genetic Testing (PGT) and Related Services			
	10%	Yes	Yes
34. Preventive Care Services			
Physician office services	None	No	No
Lab, X-ray or other preventive tests	None	No	No
Breast pumps	None	No	No
35. Prosthetic Devices			
	10%	Yes	Yes
36. 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*.		
37. Rehabilitation Services - Outpatient Therapy			
The following limitations apply: • 30 physical therapy visits per condition per year. • 30 speech therapy visits per condition per year. • 30 occupational therapy visits	10%	Yes	Yes

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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?**
per condition per year. • 90 cardiac rehabilitation therapy visits per therapy (physical, speech, occupational) per year. One program per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy for pulmonary rehabilitation therapy.			
38. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	10% None, for the first diagnostic colonoscopy in a year; 10% for any subsequent diagnostic colonoscopy in that year	Yes Yes	Yes Yes
39. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Admissions to a Skilled Nursing Facility are limited to 100 days per year.	10%	Yes	Yes
40. Surgery - Outpatient			
	10%	Yes	Yes
41. Surgical Morbid Obesity Treatment			
For Network Benefits, obesity - weight loss surgery must be received from a Designated Provider.	10%	Yes	Yes

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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?**
42. Telehealth Services			
Covered Health Care Services received from Designated Virtual Network Providers are limited to services received outside of a medical facility (for example, from home or from work) for the diagnosis and treatment of less serious medical conditions (urgent on-demand care). Covered Health Care Services include urgent on-demand care from providers who are not Designated Virtual Network Providers.	*Designated Virtual Network Providers* None	Yes	Yes
	All other Network Providers Depending upon the type of Covered Health Care Service provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.		
43. Therapeutic Treatments - Outpatient			
	10%	Yes	Yes
44. Transplantation Services			
Transplantation services must be received from a Designated Provider. We do not require that cornea transplants 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.*		
45. 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	10%	Yes	Yes

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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?**
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 under *Therapeutic Treatments - Outpatient*.			
46. Urinary Catheters			
	10%	Yes	Yes
Prescription Drug Products, including Specialty Prescription Drug, Products from a Retail or Mail Order Pharmacy			
For Prescription Drug Products at a retail 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	*Preventive Care Medications* None *Other than Preventive Care Medications*	Yes	No

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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?**
and Customary Charge for the Prescription Drug Product. • The Prescription Drug Charge for that Prescription Drug Product. For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following: • The applicable Co-payment and/or Co-insurance. • The Prescription Drug Charge for that Prescription Drug Product. Your Co-payment and/or Co-insurance will never exceed the retail price of the Prescription Drug Product. You are not responsible for paying a Co-payment and/or Co-insurance for Prescription Drug Products on the List of Zero Cost Share Medications. You will not pay in Co-payments or Co-insurance more than $30 per 30-day supply Prescription Order or Refill for insulin, regardless of the amount or type of insulin needed to fill the prescription. • A one-cycle supply of a contraceptive. You may obtain up to twelve cycles at one time. Each cycle is no less than a one-month's supply. Benefits include at least one contraceptive of each of the *FDA* approved contraceptive methods without a Co-payment or Co-insurance requirement. However, a Co-payment or Co-insurance may apply for a contraceptive drug or device that,	*Tier 1* $15 per prescription order or refill *Tier 1 - Prescription Drug Product on the List of Preventive Medications* $5 per Prescription Order or Refill. *Tier 1 - Preferred Specialty* $15 per prescription order or refill *Tier 1 - Specialty Prescription Drug Product on the List of Preventive Medications* $5 per Prescription Order or Refill *Tier 2* $40 per prescription order or refill *Tier 2 - Prescription Drug Product on the List of Preventive Medications* $5 per Prescription Order or Refill *Tier 2 - Preferred Specialty* $40 per prescription order or refill *Tier 2 - Specialty*	Yes Yes Yes Yes Yes Yes Yes	Yes No Yes No Yes No Yes

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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?**
according to the *FDA* is therapeutically equivalent to another contraceptive drug or device that is available under your plan without a Co-payment or Co-insurance requirement. For contraceptives that have a member cost share, you will pay a Co-payment or Co-insurance for each cycle supplied. Co-payments or Co-insurance for *FDA* approved contraceptive drugs dispensed without a prescription and available by prescription or over-the-counter will not exceed the Co-payment or Co-insurance for the contraceptive drug when dispensed as a prescription. Your Co-payment and/or Co-insurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product. Prescription Drug Products prescribed for abortion care services are covered at no charge.	*Prescription Drug Product on the List of Preventive Medications* $5 per Prescription Order or Refill *Tier 3* $80 per prescription order or refill *Tier 3 - Prescription Drug Product on the List of Preventive Medications* $5 per Prescription Order or Refill *Tier 3 - Preferred Specialty* $100 per prescription order or refill *Tier 3 - Specialty Prescription Drug Product on the List of Preventive Medications* $5 per Prescription Order or Refill *Tier 4* $125 per prescription order or refill *Tier 4 - Prescription Drug Product on the List of Preventive Medications* $5 per Prescription Order or Refill *Tier 4 - Preferred*	Yes Yes Yes Yes Yes Yes	No Yes No Yes No Yes No

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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?**
	Specialty $150 per prescription order or refill	Yes	Yes
	Tier 4 - Specialty Prescription Drug Product on the List of Preventive Medications $5 per Prescription Order or Refill	Yes	No
	Non-Preferred Specialty You will be required to pay 2 times the Preferred Specialty Network Co-Payment and/or 2 times the Preferred Specialty Network Pharmacy Co-insurance (up to 50% of the Prescription Drug Charge) based on the applicable Tier. You will never pay more than $150 per 30 day supply for a Specialty Prescription Drug Product.	Yes	Yes

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Allowed Amounts

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

- For Designated Network Benefits and 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 may 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 the *Certificate.* 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 may 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 the *Certificate.* We will make payment for the covered Emergency Health Care Services directly to the Out-of-Network Provider or Out-of-Network Emergency Facility, and the payment amount will be equal to the amount by which the Out-of-Network Rate exceeds the cost-sharing amount for the items and services.
- For Covered Health Care Services that are ***Emergency Health Care Services, urgent care services outside your geographic area, or if a Covered Health Care Service was preauthorized or otherwise approved by us or a Network provider, or obtained pursuant to a verbal or written referral by us or a Network provider, provided by an Out-of-Network Provider,*** you are not responsible, and the Out-of-Network Provider may 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 *Certificate.* 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 may 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 Qualifying Payment Amount as defined in the *Certificate.* We will make payment for the covered Air Ambulance services directly to the Out-of-Network Provider of Air Ambulance Services. The payment amount will be equal to the amount by which the Out-of-Network Rate exceeds the cost-sharing amount for the services. Cost sharing for these services will count towards any applicable Network Annual Deductible and Out-of-Pocket Limit.

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

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

- When Covered Health Care Services are received from a Designated Network and 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 Act* 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:

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- 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 Provider may 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 *Certificate.*

For Emergency Health Care 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 may 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 *Certificate.*

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 may 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 *Certificate.*

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 may bill you for any difference between the provider's billed charges and the Allowed Amount described here.

Note: The notice and consent criteria of *45 C.F.R. § 149.420 (c) through (i)* do not apply to Out-of-Network Providers with respect to Covered Health Care Services rendered by an on-call physician or a hospital-based physician who has obtained an assignment of benefits from the Covered Person.

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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 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 by us prior to receipt of the Covered Health Care Service that the provider was a Network provider, either through our database, our provider directory, or in our response to your request for such information (via telephone, electronic, web-based or internet-based means), your cost sharing (Co-payment, Co-insurance and applicable deductible) will be no greater than if the service had been provided from a Network provider. Also see *Cost-sharing and Balance Billing Protections for Services Provided Based on Reliance on Incorrect Provider Network Information* provision below for further details.

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 refer to the Continuity of Care provision below or call the telephone number on your ID card.

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 refer to the Continuity of Care provision below or call the telephone number on your ID card.

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.

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 non-Physician Specialist, or access to such a Network provider, or non-Physician Specialist, would require unreasonable delay or travel, you may be eligible for Network Benefits when Covered Health Care Services are received from Out-of-Network Providers or non-Physician Specialists.

In this situation, you may request a referral to an Out-of-Network Provider, or non-Physician Specialist from your Network Physician who will notify us and, if we confirm that the required specialized service or care is not available from a Network provider, or non-Physician Specialist or we cannot provide a Network Provider, or non-Physician Specialist, without unreasonable delay or travel, including within the reasonable appointment waiting time and travel distance standards established in regulation for Mental Health Care Services and Substance-Related and Addictive Disorders Services, we will work with you

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and your Network Physician to coordinate care through an Out-of-Network Provider, or non-Physician Specialist. When coordinated, such service received from an Out-of-Network Provider, or non-Physician Specialist, will be treated as Network Benefits, including any applicable Co-payment, Co-insurance and deductible requirements. Services received for Mental Health Care Services and Substance-Related and Addictive Disorders Services will be provided for the duration of the treatment plan, and 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 you are furnished, by an Out-of-Network Provider, an item or service that would otherwise be covered if provided by a Network provider, and you 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 Co-payment amount, Co-insurance percentage, and/or other cost-sharing requirement for such item or service furnished by an Out-of-Network Provider is the same as the Co-payment amount, Co-insurance percentage, and/or other cost-sharing requirement 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 the Designated Network and Network Annual Deductible and Out-of-Pocket Limit.
- You will not be liable for an amount that exceeds the cost-sharing that would have applied if the provider was a Network provider.

Limitations on Selection of Providers

If we determine that you are using health care services in a harmful or abusive manner, or with harmful frequency, your selection of Network providers may be limited. If this happens, we may require you to select a single Network Physician to provide and coordinate all future Covered Health Care Services.

If you don't make a selection within 31 days of the date we notify you, we will select a single Network Physician for you.

If you do not use the selected Network Physician, Benefits will not be paid.

Continuity of Care

In accordance with state law, 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 Care and Substance-Related and Addictive Disorders Services; and

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- 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 list 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. However, the Out-of-Network Provider has the option to decline the rate and method of payment by providing a 10 day notice to the Covered Person and to us. In this event, we may reach an agreement with the Out-of-Network Provider on an alternative rate for the payment of Covered Health Care Services. If an agreement for an alternative rate or method of payment is not reached, the Out-of-Network Provider is not required to continue to provide services. The rates and methods of payment will ensure that the Covered Person is not subject to balance billing and that the Co-payments, deductibles and any Co-insurance required are the same as if the services were received from a Network provider.

In accordance with federal law, 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 participating provider contract is terminated or non-renewed for reasons other than for failure to meet applicable quality standards or for fraud; or if the Group Policy terminates resulting in a loss of benefits with respect to such provider or facility. 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.

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Pediatric Dental Services Rider

MAMSI Life and Health Insurance Company

How Do You Use This Document?

This Rider to the Policy is issued to the Group and provides Benefits for Covered Dental Services, as described below, for Covered Persons under the age of 19. Benefits under this Rider will end on the last day of the month the Covered Person reaches the age of 19.

What Are Defined Terms?

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in either the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms* or in this Rider in *Section 4: Defined Terms for Pediatric Dental Services.*

When we use the words "we," "us," and "our" in this document, we are referring to MAMSI Life and Health Insurance Company. When we use the words "you" and "your" we are referring to people who are Covered Persons, as the term is defined in the *Certificate* in *Section 9: Defined Terms.*

Joseph Ochipinti, President and CEO

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Section 1: Accessing Pediatric Dental Services

Network Benefits

Benefits - Benefits apply when you choose to obtain Covered Dental 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 Services to be paid, you must obtain all Covered Dental Services directly from or through a Network Dental Provider, however Benefits are provided for out-of-area urgent care dental services and for certain services provided by out-of-Network Dental Providers as described below under *Dental Services from Out-of-Network Dental Providers.*

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 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 Services that are not provided by a Network Dental Provider, however Benefits are provided for out-of-area urgent care dental services and for certain services provided by out-of-Network Dental Providers as described below under *Dental Services from out-of-Network Dental Providers.*

Dental Services from Out-of-Network Dental Providers Paid as Network Benefit

If you are diagnosed with a condition or disease that requires specialized Dental Services and such specialized service or care is either not available from a Network Dental Provider or access to such a Network Dental Provider would require unreasonable delay or travel, you may be eligible for Network Benefits when Covered Dental Services are received from out-of-Network Dental Providers.

In this situation, you may request a referral to an out-of-Network Dental Provider from your Network Dental Provider who will notify us and, if we confirm that the required specialized service or care is not available from a Network Dental Provider or a Network Dental Provider is not available without unreasonable delay or travel, we will work with you and your Network Dental Provider to coordinate care through a, out-of-Network Dental Provider. When coordinated, such service received from an out-of-Network Dental Provider will be treated as Network Benefits, including any applicable Co-payment, Co-insurance and deductible requirements.

Benefits are also provided when Covered Dental Services are received from an Out-of-Network Dental Provider as a result of an Emergency at an Urgent Care Center outside your geographic area, or if a Covered Dental 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 referral by us or a Network provider.

What Are Covered Dental Services?

You are eligible for Benefits for Covered Dental Services listed in this Rider if such Dental Services are Necessary and are provided by or under the direction of a Network Dental Provider.

Benefits are available only for Necessary Dental 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 Rider.

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-

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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 Services are provided. It is your Dental Provider's responsibility for obtaining a pre-authorization.

Section 2: Benefits for Pediatric Dental Services

Benefits are provided for the Dental 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 *Section 3: Pediatric Dental Exclusions* of this Rider.

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 Services and Benefits will not be payable.

Annual Deductible

Benefits for pediatric Dental Services provided under this Rider are subject to the Annual Deductible stated in the medical *Schedule of Benefits* unless otherwise specifically stated.

Out-of-Pocket Limit - any amount you incur in Co-insurance for pediatric Dental Services under this Rider applies to the Out-of-Pocket Limit stated in the medical *Schedule of Benefits.*

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:

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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 year basis unless otherwise specifically stated.

We will provide coverage for all dental services determined to be medically necessary for problems identified during screening or diagnostic evaluations. Benefits include diagnostic services, preventative services, restorative services, endodontic services periodontic services, removable prosthodontics, oral and maxillofacial surgery, maxillofacial prosthetics, fixed prosthodontics, orthodontics for children with severe dysfunctional, handicapping malocclusion, and adjunctive general services in accordance with the American Academy of Pediatric Dentistry. Additionally, we will provide coverage for periodic screening in accordance with the periodicity schedule developed by the American Academy of Pediatric Dentistry.

Note: The following dental codes are not covered under this Pediatric Dental rider but are covered under the medical portion of your coverage. Depending upon where the Covered Dental Service is provided, Benefits will be the same as those stated under each Covered Dental Service category in the medical *Schedule of Benefits.*

- D0290 - Posterior - anterior or lateral skull and facial bone survey radiographic image
- D0310 - Sialography
- D0320 - Temporomandibular Joint Arthrogram, including injection
- D0321 - Other Temporomandibular Joint Films, by report
- D4920 - Unscheduled dressing change (by someone other than the original treating dentist)
- D5861 - Overdenture - partial, by report
- D5992 - Adjust maxillofacial prosthetic appliance, by report
- D7410 – Excision of benign lesion up to 1.25 cm
- D7440 - Excision of malignant tumor - lesion diameter up to 1.25 cm
- D7550 - Partial ostectomy/sequestrectomy for removal of non-vital bone
- D7910 - Suture of recent small wounds up to 5 cm.
- D9410 - House/extended care facility call

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Benefit Description

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 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays. D0120 - Periodic oral evaluation per provider or location. D0140 - Limited oral evaluation - problem focused. No limitation except will not be reimbursed on the same day as D0120, D0150, D0160. D9995 - Teledentistry - synchronous - real time encounter. D9996 - Teledentistry - asynchronous - information stored and forwarded to dentist for subsequent review. D0145 – Oral evaluation – For patients under 3 years of age per provider or location. D0150 - Comprehensive oral evaluation per provider or location. D0160 - Detailed and extensive oral evaluation - problem focused, by report per provider or location. D0180 - Comprehensive periodontal evaluation - new or established patient.	None
Intraoral Radiographs (X-ray) Limited to 1 series of films per 36 months per provider or location. D0210 - Intraoral - comprehensive series of radiographic images. D0709 - Intraoral - comprehensive series of radiographic images - image capture only. D0372 - Intraoral tomosynthesis - comprehensive series of radiographic images. D0387 - Intraoral tomosynthesis - comprehensive series of radiographic images - image capture only.	None

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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. D0220 - Intraoral - periapical first film. D0230 - Intraoral - periapical each additional radiographic image. D0250 – Extra Oral – 2D projection. D0270 - Bitewings - single film D0706 - Intraoral - occlusal radiographic image - image capture only. D0707 - Intraoral - periapical radiographic image - image capture only. The following services are limited to 2 per 12 months. D0240 - Intraoral - occlusal film. D0374 - Intraoral tomosynthesis - periapical radiographic image. D0389 - Intraoral tomosynthesis - periapical radiographic image - image capture only.	None
Any combination of the following services is limited to 2 series of films per 12 months. D0272 - Bitewings - two radiographic images per provider or location. D0273 – Bitewings – Three films per provider or location. D0274 - Bitewings - four radiographic images per provider or location. D0708 - Intraoral - bitewing radiographic image - image capture only.	None
Limited to 1 time per 36 months. D0277 - Vertical bitewings - 7 to 8 radiographic images. D0330 - Panoramic radiograph image per provider or location. D0701 - Panoramic radiographic image - image capture only. D0702 - 2-D Cephalometric radiographic image - image capture only.	None

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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 limited to two images per year. D0373 - Intraoral tomosynthesis - comprehensive series of radiographic images. D0388 - Intraoral tomosynthesis - bitewing radiographic image - image capture only. D0705 - Extra-oral posterior dental radiographic image - image capture only.	None
The following services are not subject to a frequency limit. D0340 - Cephalometric X-ray. D0350 - Oral/facial photographic images obtained intra-orally or extra-orally. D0460 – Pulp vitality tests D0470 - Diagnostic casts. D0703 - 2-D Oral/facial photographic image obtained intra-orally or extra-orally - image capture only.	None
Preventive Services - (Not subject to payment of the Annual Deductible.)	
Dental Prophylaxis (Cleanings) The following services are limited to two times every 12 months. D1110 - Prophylaxis - adult per provider or location. D1120 - Prophylaxis - child per provider or location	None
Fluoride Treatments The following services are limited to eight times every year. D1206 - Fluoride - Ages 0 - 2 per patient The following services are limited to four times every year. D1206 - Fluoride - Ages 3 and above per provider or location. D1208 - Fluoride	None
Sealants (Protective Coating)	None

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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 once per first or second permanent molar every 36 months. D1351 - Sealant - per tooth. D1352 - Preventive resin restorations per tooth in moderate to high caries risk patient - permanent tooth.	
Space Maintainers (Spacers) The following services are not subject to a frequency limit. D1510 - Space maintainer - fixed, unilateral - per quadrant. D1516 - Space maintainer - fixed - bilateral, maxillary. D1517 - Space maintainer - fixed - bilateral, mandibular. D1520 - Space maintainer - removable, unilateral - per quadrant. D1526 - Space maintainer - removable - bilateral, maxillary. D1527 - Space maintainer - removable - bilateral, mandibular. D1550 - Re-cementation of space maintainer. D1551 - Re-cement or re-bond bilateral space maintainer - maxillary. D1552 - Re-cement or re-bond bilateral space maintainer - mandibular. D1553 - Re-cement or re-bond unilateral space maintainer - per quadrant. D1555 - Removal of fixed space maintainer. D1556 - Removal of fixed unilateral space maintainer - per quadrant. D1557 - Removal of fixed bilateral space maintainer - maxillary. D1558 - Removal of fixed bilateral space maintainer - mandibular. D1575 - Distal shoe space maintainer - fixed - unilateral - per quadrant.	None

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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.**
Minor Restorative Services - (Subject to payment of the Annual Deductible.)	
Amalgam Restorations (Silver Fillings) The following services are not subject to a frequency limit. D2140 - Amalgams - one surface, primary or permanent. D2150 - Amalgams - two surfaces, primary or permanent. D2160 - Amalgams - three surfaces, primary or permanent. D2161 - 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. D2330 - Resin-based composite - one surface, anterior. D2331 - Resin-based composite - two surfaces, anterior. D2332 - Resin-based composite - three surfaces, anterior. D2335 - Resin-based composite - four or more surfaces (anterior). D2390 – Resin based composite crown – anterior. D2391 – Resin based composite – one surface, posterior. D2392 – Resin based composite – two surfaces, posterior. D2393 – Resin based composte – three surfaces, posterior. D2394 – Resin based composte – four or more surfaces, posterior. D2989 – Excavation of a tooth resulting in the determination of non-restorability.	20%
Crowns/Inlays/Onlays (Subject to payment of the Annual Deductible.)	

SAMPLE

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 per patient per tooth every 60 months. D2542 - Onlay - metallic - two surfaces. D2543 - Onlay - metallic - three surfaces. D2544 - Onlay - metallic - four or more surfaces. D2721 – Crown – resin with base metal. D2740 - Crown - porcelain/ceramic substrate. D2750 - Crown - porcelain fused to high noble metal. D2751 - Crown - porcelain fused to predominately base metal. D2752 - Crown - porcelain fused to noble metal. D2753 - Crown - porcelain fused to titanium and titanium alloys. D2780 - Crown - 3/4 cast high noble metal. D2781 - Crown - 3/4 cast predominately base metal. D2782 – Crown – ¾ cast noble metal. D2783 - Crown - 3/4 porcelain/ceramic. D2790 - Crown - full cast high noble metal. D2791 - Crown - full cast predominately base metal. D2792 - Crown - full cast noble metal. D2794 - Crown - titanium and titanium alloys. D2931 - Prefabricated stainless steel crown - permanent tooth. The following services are subject to a limit of one time per patient per tooth, every 36 months. D2928 - Prefabricated porcelain/ceramic crown – permanent tooth. D2930 - Prefabricated stainless steel crown - primary tooth per 36 months, per patient, per tooth. D2932 – Prefabricated resin crown D2933 – Prefabricated stainless steel crown with resin window. D2934 – Prefabricated esthetic coated stainless	50%

SAMPLE

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.**
steel crown, primary tooth. The following services are not subject to a frequency limit. D2510 - Inlay - metallic - one surface. D2520 - Inlay - metallic - two surfaces. D2530 - Inlay - metallic - three surfaces. D2910 - Re-cement inlay or rebond. D2920 - Re-cement crown or rebond.	
The following service is not subject to a frequency limit. D2940 - Placement of interim direct restoration.	50%
The following services are limited to one time per tooth every 60 months. D2950 - Core buildup, including any pins. D2960 – Labial veneers – resin chairside D2961 – Labial veneers – resin laboratory D2962 – Labial veneers – Porcelain laboratory	50%
The following services are not subject to a frequency limit. D2951 - Pin retention - per tooth, in addition to restoration. D2952 – Post and Core in addition to crown D2954 - Prefabricated post and core in addition to crown. D2980 - Crown repair necessitated by restorative material failure. D2981 - Inlay repair necessitated by restorative material failure. D2982 - Onlay repair necessitated by restorative material failure.	50%
Endodontics - (Subject to payment of the Annual Deductible.)	
No limitation except will not be reimbursed on the same day as D3346, D3347, D3348. D2955 - Post Removal (not in conjunction with	20%

SAMPLE

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.**
endodontic therapy)	
The following services are not subject to a frequency limit. D3110 – Pulp Cap – Direct D3120 – Pulp Cap - Indirect D3220 - Therapeutic pulpotomy (excluding final restoration). D3221 – Pulpal debridement D3222 - Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development. D3230 - Pulpal therapy (resorbable filling) - anterior primary tooth (excluding final restoration). D3240 - Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).	20%
The following services are not subject to a frequency limit. D3310 - Endodontic therapy anterior tooth (excluding final restoration). D3320 - Endodontic therapy, premolar tooth (excluding final restoration). D3330 - Endodontic therapy, molar tooth (excluding final restoration). D3346 - Retreatment of previous root canal therapy - anterior. D3347 - Retreatment of previous root canal therapy - premolar. D3348 - Retreatment of previous root canal therapy - molar.	20%
The following services are not subject to a frequency limit. D3351 - Apexification/recalcification - initial visit. D3352 - Apexification/recalcification/pulpal regeneration - interim medication replacement. D3353 - Apexification/recalcification - final visit.	20%
The following services are not subject to a	20%

SAMPLE

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.**
frequency limit. D3355 - Pulpal regeneration - initial visit D3356 - Pulpal regeneration - interim medication replacement D3357 - Pulpal regeneration - completion of treatment	
The following services are not subject to a frequency limit. D3410 - Apicoectomy - anterior. D3421 - Apicoectomy - premolar (first root). D3425 - Apicoectomy - molar (first root). D3426 - Apicoectomy (each additional root). D3430 – Retrograde filling – per root. D3450 - Root amputation - per root. D3470 – Intentional re-implantation. D3471 - Surgical repair of root resorption - anterior. D3472 - Surgical repair of root resorption - premolar. D3473 - Surgical repair of root resorption - molar. D3501 - Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior. D3502 - Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar. D3503 - Surgical exposure of root surface without apicoectomy or repair of root resorption - molar.	20%
The following services are not subject to a frequency limit. D3911 - Intraorifice barrier. D3920 - Hemisection (including any root removal), not including root canal therapy.	20%
Periodontics - (Subject to payment of the Annual Deductible.)	
The following services are limited to a frequency of one per 24 months, per quadrant. D4210 - Gingivectomy or gingivoplasty - four or	20%

SAMPLE

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.**
more contiguous teeth or tooth bounded spaces per quadrant. D4211 - Gingivectomy or gingivoplasty - one to three teeth. D4212 - Gingivectomy or gingivoplasty - with restorative procedures, per tooth.	
The following services are limited to one per 24 months, per quadrant. D4230 – Anatomical crown exposure – four or more D4231 – Anatomical crown exposure – one to three D4240 - Gingival flap procedure, including root planing - four or more teeth. D4241 - 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 tooth. D4249 - Clinical crown lengthening - hard tissue.	20%
The following services are limited to one per 24 months, per quadrant. D4260 - Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant. D4261 - Osseous surgery (including flap entry and closure), one to three contiguous teeth or bounded teeth spaces per quadrant.	20%
The following services are limited to one every 36 months. D4263 - Bone replacement graft - retained natural tooth - first site in quadrant. D4286 - Removal of non-resorbable barrier.	20%
The following service is not subject to a frequency limit. D4270 - Pedicle soft tissue graft procedure.	20%

SAMPLE

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. D4273 - Autogenous connective tissue graft procedure, per first tooth implant or edentulous tooth position in graft. D4275 - Non-autogenous connective tissue graft first tooth implant. D4277 - Free soft tissue graft procedure - first tooth. D4278 - Free soft tissue graft procedure - each additional contiguous tooth. D4322 - Splint - intra-coronal; natural teeth or prosthetic crowns. D4323 - Splint - extra-coronal; natural teeth or prosthetic crowns.	20%
The following services are limited to one time per quadrant every 24 months. D4341 - Periodontal scaling and root planing - four or more teeth per quadrant. D4342 - Periodontal scaling and root planing - one to three teeth per quadrant. D4346 - Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation. *The following services are not subject to a frequency limit.* D4320 – provisional splinting – intracoronal D4321 – provisional splinting - extracoronal	20%
The following service is limited to a frequency to one per 24 months. Not allowed on same day as D1110. D4355 - Full mouth debridement to enable comprehensive oral evaluation and diagnosis on a subsequent visit.	20%
The following service is limited to four times every 12 months. D4910 - Periodontal maintenance.	20%

SAMPLE

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.**
Removable Dentures - (Subject to payment of the Annual Deductible.)	
The following services are limited to a frequency of one every 60 months. D5110 - Complete denture - maxillary. D5120 - Complete denture - mandibular. D5130 - Immediate denture - maxillary. D5140 - Immediate denture - mandibular. D5211 - Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth). D5212 - Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth). D5213 - Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth). D5214 - Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth). D5221 - Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth). D5222 - Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth). D5223 - Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth). D5224 - Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth). D5225 – Maxillary partial denture – flexible base. D5226 – Mandibular partial denture – flexible base. D5227 - Immediate maxillary partial denture - flexible base (including any clasps, rests, and teeth). D5228 - Immediate mandibular partial denture -	50%

SAMPLE

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.**
flexible base (including any clasps, rests, and teeth). D5282 - Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary. D5283 - Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular. D5284 - Removable unilateral partial denture - one piece flexible base (including retentive/clasping materials, rests, and teeth) - per quadrant. D5286 - Removable unilateral partial denture - one piece resin (including retentive/clasping materials, rests, and teeth) - per quadrant.	
The following services are not subject to a frequency limit. D5410 - Adjust complete denture - maxillary. D5411 - Adjust complete denture - mandibular. D5421 - Adjust partial denture - maxillary. D5422 - Adjust partial denture - mandibular. D5510 - Repair broken complete denture base. D5511 - Repair broken complete denture base - mandibular. D5512 - Repair broken complete denture base - maxillary. D5520 - Replace missing or broken teeth - complete denture per tooth. D5610 - Repair resin denture base. D5611 - Repair resin partial denture base - mandibular. D5612 - Repair resin partial denture base - maxillary. D5621 - Repair cast partial framework - mandibular. D5620 - Repair cast framework. D5622 - Repair cast partial framework - maxillary. D5630 - Repair or replace broken	50%

SAMPLE

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.**
retentive/clasping materials - per tooth. D5640 - Replace broken teeth partial denture - per tooth. D5650 - Add tooth to existing partial denture. D5660 - Add clasp to existing partial denture - per tooth.	
The following services are limited to rebasing performed more than 6 months after the initial insertion with a frequency limitation of one time per 12 months. D5710 - Rebase complete maxillary denture. D5711 - Rebase complete mandibular denture D5720 - Rebase maxillary partial denture. D5721 - Rebase mandibular partial denture. D5725 - Rebase hybrid prosthesis. D5730 - Reline complete maxillary denture (direct). D5731 - Reline complete mandibular denture (direct). D5740 - Reline maxillary partial denture (direct). D5741 - Reline mandibular partial denture (direct). D5750 - Reline complete maxillary denture (indirect). D5751 - Reline complete mandibular denture (indirect). D5760 - Reline maxillary partial denture (indirect). D5761 - Reline mandibular partial denture (indirect). D5876 - Add metal substructure to acrylic full denture (per arch).	50%
The following services are not subject to a frequency limit. D5765 - Soft liner for complete or partial removable denture - indirect. D5850 - Tissue conditioning (maxillary). D5851 - Tissue conditioning (mandibular).	50%

SAMPLE

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.**
D5863 Overdenture – complete maxillary. D5864 Overdenture – partial maxillary. D5865 Overdenture – complete mandibular. D5866 Overdenture – partial mandibular.	
Bridges (Fixed partial dentures (FPD)) - (Subject to payment of the Annual Deductible.)	
The following services are not subject to a frequency limit. D6210 - Pontic - cast high noble metal. D6211 - Pontic - cast predominately base metal. D6212 - Pontic - cast noble metal. D6214 - Pontic - titanium and titanium alloys. D6240 - Pontic - porcelain fused to high noble metal. D6241 - Pontic - porcelain fused to predominately base metal. D6242 - Pontic - porcelain fused to noble metal. D6243 - Pontic - porcelain fused to titanium and titanium alloys. D6245 - Pontic - porcelain/ceramic.	50%
The following services are not subject to a frequency limit. D6545 - Retainer - cast metal for resin bonded fixed prosthesis. D6548 - Retainer - porcelain/ceramic for resin bonded fixed prosthesis.	50%
The following services are limited to one time every 60 months. D6740 - Retainer crown - porcelain/ceramic. D6750 - Retainer crown - porcelain fused to high noble metal. D6751 - Retainer crown - porcelain fused to predominately base metal. D6752 - Retainer crown - porcelain fused to noble metal.	50%

SAMPLE

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.**
D6753 - Retainer crown - porcelain fused to titanium and titanium alloys. D6780 - Retainer crown - 3/4 cast high noble metal. D6781 - Retainer crown - 3/4 cast predominately base metal. D6782 - Retainer crown - 3/4 cast noble metal. D6783 - Retainer crown - 3/4 porcelain/ceramic. D6784 - Retainer crown - 3/4 titanium and titanium alloys. D6790 - Retainer crown - full cast high noble metal. D6791 - Retainer crown - full cast predominately base metal. D6792 - Retainer crown - full cast noble metal.	
The following service is not subject to a frequency limit. D6930 - Re-cement or re-bond FPD. D6980 - FPD repair necessitated by restorative material failure.	50%
Oral Surgery - (Subject to payment of the Annual Deductible.)	
The following services are not subject to a frequency limit. D7111 – Extraction, coronal remnants - primary tooth. D7140 - Extraction, erupted tooth or exposed root. D7210 - Surgical removal of erupted tooth requiring removal of bone, sectioning of tooth, and including elevation of mucoperiosteal flap, if indicated. D7220 - Removal of impacted tooth - soft tissue. D7230 - Removal of impacted tooth - partially bony. D7240 - Removal of impacted tooth - completely bony. D7241 - Removal of impacted tooth - completely bony with unusual surgical complications. D7250 - Surgical removal or residual tooth roots. D7251 - Coronectomy - intentional partial tooth	20%

SAMPLE

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, impacted teeth only.	
The following services are not subject to a frequency limit. D7260 – Oroantral fistula closure D7270 - Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth. D7272 – Tooth transplantation	20%
The following services are not subject to a frequency limit. D7280 - Surgical access of an unerupted tooth. D7285 – Incisional biopsy of oral tissure – hard D7286 – Incisional biopsy of oral tissure – soft D7290 – Surgical repositioning of teeth	20%
The following services are not subject to a frequency limit. D7310 - Alveoloplasty in conjunction with extractions - per quadrant. D7311 - Alveoloplasty in conjunction with extraction - one to three teeth or tooth spaces - per quadrant. D7320 - Alveoloplasty not in conjunction with extractions - per quadrant. D7321 - Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces - per quadrant. D7340 – Vestibuloplasty – ridge extension, secondary epithelialization D7350 – Vestibuloplasty – ridge extension, including soft tissue grafts	20%
The following services are not subject to a frequency limit. D7450 – Removal of benign odontogenic cyst or tumor – up to 1.25 cm D7451 – Removal of benign odontogenic cyst or tumor – greater than 1.25 cm D7460 – Removal of benign nondontogenic cyst or	20%

SAMPLE

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.**
tumor up to 1.25 cm D7461 – Removal of benign nondontogenic cyst or tumor greater than 1.25 cm D7471 - removal of lateral exostosis (maxilla or mandible). D7472 – Removal of torus palatinus D7473 – Removal of torus mandibularis	
The following services are not subject to a frequency limit. D7509 - Marsupialization of odontogenic cyst. D7510 - Incision and drainage of abscess, intraoral soft tissue. D7520 - Incision and drainage of abscess - extraoral soft tissue D7910 - Suture of recent small wounds up to 5 cm. D7953 - Bone replacement graft for ridge preservation - per site. D7961 - Buccal/labial frenectomy (frenulectomy). D7962 - Lingual frenectomy (frenulectomy). D7970 – Excision of hyperplastic tissue. D7971 - Excision of pericoronal gingiva.	20%
The following services are limited to one every 36 months. D7956 - Guided tissue regeneration, edentulous area - resorbable barrier, per site. D7957 - Guided tissue regeneration, edentulous area - non-resorbable barrier, per site.	20%
Adjunctive Services - (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. D9110 - Palliative (Emergency) treatment of dental pain - per visit.	20%

SAMPLE

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.**
Covered only when clinically Necessary. D9222 - Deep sedation/general anesthesia - first 15 minutes. D9223 - Deep sedation/general anesthesia - each 15 minute increment. D9239 - Intravenous moderate (conscious) sedation/anesthesia - first 15 minutes. D9230 - Inhalation of nitrous oxide/anxiolysis, analgesia. Will not be reimbursed with D9248. D9243 - Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment. D9248 – Non-intravenous conscious sedation D9610 - Therapeutic parenteral drug single administration. D9910 – Application of desensitizing medicament	20%
Covered only when clinically Necessary. D9310 - Consultation (diagnostic service provided by a dentist or Physician other than the practitioner providing treatment).	20%
The following services are not subject to a frequency limit. D9941 – Fabrication of athletic mouthguard D9951 – Occlusal adjustment – limited D9952 – Occlusal adjustment - complete	20%
The following services are limited to one guard every 12 months. D9944 - Occlusal guard - hard appliance, full arch. D9945 - Occlusal guard - soft appliance, full arch. D9946 - Occlusal guard - hard appliance, partial arch.	20%
Implant Procedures - (Subject to payment of the Annual Deductible.)	
The following services are limited to one per 6 months per patient per arch. D5993 - Maintenance and cleaning of a	50%

SAMPLE

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.**
maxillofacial prosthesis (extra or intraoral) other than required adjustments. The following services are limited to one time every 60 months. D6010 - Surgical placement of implant body: endosteal implant. D6012 - Surgical placement of interim implant body. D6040 - Surgical placement of eposteal implant. D6050 - Surgical placement: transosteal implant. D6055 - Connecting bar - implant supported or abutment supported. D6056 - Prefabricated abutment - includes modification and placement. D6057 - Custom fabricated abutment - includes placement. D6058 - Abutment supported porcelain/ceramic crown. D6059 - Abutment supported porcelain fused to metal crown (high noble metal). D6060 - Abutment supported porcelain fused to metal crown (predominately base metal). D6061 - Abutment supported porcelain fused to metal crown (noble metal). D6062 - Abutment supported cast metal crown (high noble metal). D6063 - Abutment supported cast metal crown (predominately base metal). D6064 - Abutment supported cast metal crown (noble metal). D6065 - Implant supported porcelain/ceramic crown. D6066 - Implant supported crown - porcelain fused to high noble alloys. D6067 - Implant supported crown - high noble alloys. D6068 - Abutment supported retainer for porcelain/ceramic FPD.	

SAMPLE

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.**
D6069 - Abutment supported retainer for porcelain fused to metal FPD (high noble metal). D6070 - Abutment supported retainer for porcelain fused to metal FPD (predominately base metal). D6071 - Abutment supported retainer for porcelain fused to metal FPD (noble metal). D6072 - Abutment supported retainer for cast metal FPD (high noble metal). D6073 - Abutment supported retainer for cast metal FPD (predominately base metal). D6074 - Abutment supported retainer for cast metal FPD (noble metal). D6075 - Implant supported retainer for ceramic FPD. D6076 - Implant supported retainer for FPD - porcelain fused to high noble alloys. D6077 - Implant supported retainer for metal FPD - high noble alloys. D6080 - Implant maintenance procedure when a full arch fixed hybrid prosthesis is removed and reinserted, including cleansing of prosthesis and abutments. D6081 - Scaling and debridement of a single implant in the presence of mucositis, including inflammation, bleeding upon probing, and increased pocket depths; includes cleaning of the implant surfaces, without flap entry and closure. D6082 - Implant supported crown - porcelain fused to predominantly base alloys. D6083 - Implant supported crown - porcelain fused to noble alloys. D6084 - Implant supported crown - porcelain fused to titanium and titanium alloys. D6086 - Implant supported crown - predominantly base alloys. D6087 - Implant supported crown - noble alloys. D6088 - Implant supported crown - titanium and titanium alloys. D6089 - Accessing and retorquing loose implant	

SAMPLE

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.**
screw per screw. D6090 - Repair of implant/abutment supported prosthesis. D6091 - Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment. D6096 - Remove broken implant retaining screw. D6097 - Abutment supported crown - porcelain fused to titanium and titanium alloys. D6098 - Implant supported retainer - porcelain fused to predominantly base alloys. D6099 - Implant supported retainer for FPD - porcelain fused to noble alloys. D6100 - Surgical removal of implant body. D6101 - Debridement peri-implant defect. D6102 - Debridement and osseous contouring of a peri-implant defect. D6103 - Bone graft for repair peri-implant defect. D6104 - Bone graft at time of implant replacement. D6105 - Removal of implant body not requiring bone removal nor flap elevation. D6118 - Implant/abutment supported interim fixed denture for edentulous arch - mandibular. D6119 - Implant/abutment supported interim fixed denture for edentulous arch - maxillary. D6120 - Implant supported retainer - porcelain fused to titanium and titanium alloys. D6121 - Implant supported retainer for metal FPD - predominantly base alloys. D6122 - Implant supported retainer for metal FPD - noble alloys. D6123 - Implant supported retainer for metal FPD - titanium and titanium alloys. D6180 - Implant maintenance procedures when a full arch fixed hybrid prosthesis is not removed, including cleansing of prosthesis and abutments. D6190 - Radiographic/surgical implant index, by	

SAMPLE

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.**
report. D6191 - Semi-precision abutment - placement. D6192 - Semi-precision attachment - placement. D6195 - Abutment supported retainer - porcelain fused to titanium and titanium alloys. D6197 - Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant.	
The following services are limited to one every 36 months. D6106 - Guided tissue regeneration - resorbable barrier, per implant. D6107 - Guided tissue regeneration - non-resorbable barrier, per implant.	50%
Medically Necessary Orthodontics - (Subject to payment of the Annual Deductible.) Benefits for comprehensive orthodontic treatment are approved by us, only for Covered Persons with severe dysfunctional, handicapping malocclusion. All orthodontic treatment must be pre-authorized. It is your Dental Provider's responsibility for obtaining a pre-authorization. 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.	
The following services are not subject to a frequency limitation as long as benefits have been pre-authorized. D8010 - Limited orthodontic treatment of the primary dentition. D8020 - Limited orthodontic treatment of the transitional dentition. D8030 - Limited orthodontic treatment of the adolescent dentition. D8070 - Comprehensive orthodontic treatment of the transitional dentition. D8080 - Comprehensive orthodontic treatment of	50%

SAMPLE

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 adolescent dentition. D8090 – Comprehensive orthodontic treatment of the adult dentition D8210 - Removable appliance therapy. D8220 - Fixed appliance therapy. D8660 - Pre-orthodontic treatment examination to monitor growth and development. D8670 - Periodic orthodontic treatment visit. D8671 - Periodic orthodontic treatment visit associated with orthognathic surgery. D8680 - Orthodontic retention. D8695 - Removal of fixed orthodontic appliances for reasons other than completion. D8696 - Repair of orthodontic appliance - maxillary. D8697 - Repair of orthodontic appliance - mandibular. D8698 - Re-cement or re-bond fixed retainer - maxillary. D8699 - Re-cement or re-bond fixed retainer - mandibular. D8701 - Repair of fixed retainer, includes reattachment - maxillary. D8702 - Repair of fixed retainer, includes reattachment - mandibular. D8703 - replacement of lost or broken retainer – maxillary. D8704 - replacement of lost or broken retainer - mandibular.	

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Section 3: Pediatric Dental Limitations and Exclusions

Except as may be specifically provided in this Rider under *Section 2: Benefits for Pediatric Dental Services,* Benefits are limited under this Rider for the following:

1. Covered Dental Services must be performed by or under the supervision of a Dental Provider, within the scope of practice for which licensure or certification has been obtained.
2. Benefits will be limited to standard procedures and will not be provided for personalized restoration or specialized techniques in the construction of dentures, including precision attachments and custom denture teeth.

3. If a member switches from one Dental Provider to another during a course of treatment, or if more than one Dental Provider renders services for one dental procedure, we will pay as if only one Dental Provider rendered the service.
4. We will reimburse only after all dental procedures for the condition being treated have been completed (this limitation does not apply to covered orthodontic services).
5. In the event there are alternative dental procedures that meet generally accepted standards of professional dental care for a member's condition, benefits will be based upon the lowest cost alternative.
6. Benefits for radiographs are limited to radiographs required for proper treatment and/or diagnosis. Benefits for some or multiple radiographs of the same tooth or area may be denied if the Dental Plan determines the number to be redundant, excessive, or not in keeping with the federal guidelines relating to radiation exposure. The maximum amount paid for individual radiographs taken on the same day will be limited to the Allowed Benefit for a full month series.
7. When restorations involving multiple surfaces are requested or performed, that are outside the usual anatomical expectation, the Allowed Benefit is limited to that of a one-surface restoration. Any charges in excess of the Allowed Benefit for the one-surface restoration are not Covered Dental Services.

Except as may be specifically provided in this Rider under *Section 2: Benefits for Pediatric Dental Services,* Benefits are excluded under this Rider for the following:

1. Any dental service stated in *Section 2: Benefits for Pediatric Dental Services* for members over the age nineteen (19). If the member is under age nineteen (19) at the start of the benefit period but turns nineteen (19) during the benefit period, then the member will receive Covered Dental Services through the last day of the month the Covered Person reaches the age of nineteen (19).
2. The cost of services that are furnished without charge or are normally furnished without charge if a member was not covered under this Rider or under any dental insurance, or any charge or any portion of a charge which by law the provider is not permitted to bill or collect from the member directly.
3. Any service, supply, or procedure that is not specifically listed as Covered Dental Services (even if Medically Necessary) or that do not meet all other conditions and criteria for coverage as determined by Us.
4. Replacement of a denture or crown as a result of loss or theft.
5. Replacement of an existing denture or crown that is determined by Us to be satisfactory or repairable.
6. Replacement of dentures or crowns within sixty (60) months from the date of placement or replacement.
7. Gold foil fillings.
8. Periodontal appliances.
9. Splinting, except for intracoronal and extracoronal splinting.
10. Night guards or other oral orthotic appliances unless specifically listed as a Covered Dental Service.
11. Bacteriologic studies, histopathology exams, accession of tissue, caries susceptibility tests, diagnostic radiographs, and other pathology procedures, unless specifically listed as a Covered Dental Service.
12. Intentional tooth reimplantation or transplantation, unless specifically listed as a Covered Dental Service and authorized by the Dental Plan.

SAMPLE

13. Interim prosthetic devices, fixed or removable and not part of a permanent or restorative prosthetic service.
14. Tissue conditioning unless rendered prior to new denture impressions.
15. Additional fees charged for visits by a Dental Provider to the member's home, to a hospital, to a nursing home, or for office visits after the Dental Provider's standard office hours. We shall provide the benefits for the dental service as if the visit was rendered in the Dentist's office during normal office hours.
16. Transseptal fiberotomy.
17. The repair or replacement of any orthodontic appliance, unless specifically listed as a Covered Dental Service.
18. Any orthodontic services after the last day of the month in which Covered Dental Services ended except as specifically stated herein.
19. Services or supplies that are related to an excluded service (even if those services or supplies would otherwise be Covered Dental Services).
20. Separate billings for dental care services or supplies furnished by an employee of a Dental Provider which are normally included in the Dental Provider's charges and billed for by them.
21. Services that are beyond the scope of the license of the provider performing the service.
22. Adjustments to dentures made within six (6) months of initial placement.
23. Rebase and/or reline denture within six (6) months of initial placement and limited to one (1) per twenty-four (24) months after the six (6) months following initial placement.
24. A preformed denture with teeth already mounted forming a denture module.
25. Crowns when received within thirty (30) days of the date of service of a root canal or restoration on the same tooth.
26. Extraction of asymptomatic impacted teeth unless removal constitutes the most cost-effective dental procedure for the provision of dentures.
27. Unless otherwise stated in *Section 2: Benefits for Pediatric Dental Services,* dentures solely for Cosmetic purposes.
28. Unless otherwise stated in *Section 2: Benefits for Pediatric Dental Services,* orthodontic services solely for Cosmetic purposes.
29. Transitional orthodontic appliance, including a lower lingual holding arch placed where there is not premature loss of the primary molar.

Section 4: Defined Terms for Pediatric Dental Services

The following definitions are in addition to those listed in *Section 9: Defined Terms of the Certificate:*

Allowed Dental Amounts - Allowed Dental Amounts for Covered Dental Services, incurred while the Policy is in effect, are our contracted fee(s) for Covered Dental Services with that provider. Except that dental care or treatment may be provided while the Policy is not in effect according to the provision above, *Benefits after Coverage Termination for Dental Services.*

Covered Dental Service - a Dental Service or Dental Procedure for which Benefits are provided under this Rider.

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 Services, perform dental surgery or provide anesthetics for dental surgery.

Dental 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

SAMPLE

generally accepted form of care or treatment according to prevailing standards of dental practice. Except that dental care or treatment may be provided while the Policy is not in effect according to the provision above, *Benefits after Coverage Termination for Dental Services.*

Necessary - Dental Services and supplies under this Rider 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 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 Service as defined in this Rider. The definition of Necessary used in this Rider relates only to Benefits under this Rider and differs from the way in which a Dental Provider engaged in the practice of dentistry may define necessary.

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Pediatric Vision Care Services Rider

MAMSI Life and Health Insurance Company

Gold 1

How Do You Use This Document?

This Rider to the Policy is issued to the Group and provides Benefits for Vision Care Services, as described below, for Covered Persons under the age of 19. Benefits under this Rider will end on the last day of the month the Covered Person reaches the age of 19.

What Are Defined Terms?

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in either the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms* or in this Rider in *Section 4: Defined Terms for Pediatric Vision Care Services.*

When we use the words "we," "us," and "our" in this document, we are referring to MAMSI Life and Health Insurance Company. When we use the words "you" and "your" we are referring to people who are Covered Persons, as the term is defined in the *Certificate* in *Section 9: Defined Terms.*

Joseph Ochipinti, President and CEO

SAMPLE

Section 1: Benefits for Pediatric Vision Care Services

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 1-800-839-3242. You may also access a listing of UnitedHealthcare Vision Network Vision Care Providers on the Internet at www.myuhcvision.com.

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

When obtaining these Vision Care Services from a UnitedHealthcare Vision Network Vision Care Provider, you will be required to pay any Co-insurance at the time of service.

Benefits:

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.

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

Annual Deductible

What Are the Benefit Descriptions?

Benefits

Benefit limits are calculated on a 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* below.

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.
- Retinoscopy (when needed) - helps to determine the starting point of the refraction which determines the lens power of the glasses.
- Phorometry/Binocular testing - far and near (how well eyes work as a team).
- Tests of accommodation - how well you see up close (for example, reading).

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- 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.

If you purchase *Eyeglass Lenses* and *Eyeglass Frames* at the same time from the same UnitedHealthcare Vision Network Vision Care Provider, only one Co-payment will apply to those Eyeglass Lenses and Eyeglass Frames together.

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.

If you purchase *Eyeglass Lenses* and *Eyeglass Frames* at the same time from the same UnitedHealthcare Vision Network Vision Care Provider, only one Co-payment will apply to those Eyeglass Lenses and Eyeglass Frames together.

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 (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.

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.

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- 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.

Benefits after Coverage Termination for Vision Care Services

Coverage will be provided for glasses or contact lenses, according to the terms of this Rider, if the glasses or contact lenses:

- were ordered before the termination date; and
- are received within 30 days after the date of the order.

SAMPLE

Schedule of Benefits

Vision Care Service	What Is the Frequency of Service?	Benefit - The Amount You Pay Based on the Contracted Rate
Routine Vision Exam	Once per year.	10% Not subject to payment of the Annual Deductible.
Eyeglass Lenses	Once per year.	
• Single Vision		50%
• Bifocal		50%
• Trifocal		50%
• Lenticular		50%
Lens Extras		
• Polycarbonate lenses	Once per year.	None
• Standard scratch-resistant coating	Once per year.	None
Eyeglass Frames	Once per year.	
• Eyeglass frames with a retail cost up to $130.		50%
• Eyeglass frames with a retail cost of $130 - 160.		50%
• Eyeglass frames with a retail cost of $160 - 200.		50%
• Eyeglass frames with a retail cost of $200 -250.		50%
• Eyeglass frames with a retail cost greater than $250.		50%
Contact Lenses and Fitting & Evaluation		
• Contact Lens Fitting & Evaluations	Once per year.	None Not subject to payment of the Annual Deductible.

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Vision Care Service	What Is the Frequency of Service?	Benefit - The Amount You Pay Based on the Contracted Rate
• Covered Contact Lens Selection	Limited to a 12 month supply per year.	50%
Necessary Contact Lenses	Limited to a 12 month supply per year.	50%
Low Vision Care Services	Comprehensive low vision examination once every 5 years, including 4 follow-up visits in any 5-year period.	
• Low vision testing		None Not subject to payment of the Annual Deductible.
• Low vision therapy & Optical Low Vision Aids		25% of billed charges. Not subject to payment of the Annual Deductible.

Section 2: Pediatric Vision Exclusions

Except as may be specifically provided in this Rider under *Section 1: Benefits for Pediatric Vision Care Services,* Benefits are not provided under this Rider 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 *Certificate.*
2. Vision Care Services received from a non-UnitedHealthcare Vision Network Vision Care Provider.
3. Non-prescription items (e.g. Plano lenses).
4. Replacement of lost and/or stolen eyewear.
5. Optional Lens Extras not listed in *Section 1: Benefits for Pediatric Vision Care Services.*
6. Missed appointment charges.
7. Applicable sales tax charged on Vision Care Services.
8. Payment of any claim, bill, or other demand or request for payment for health care services that the appropriate regulatory board determines were provided as a result of a prohibited referral. "Prohibited referral" means a referral prohibited by *1-302* of the *Maryland Health Occupations Article.*

Section 3: Claims for Low Vision Care Services

When obtaining Low Vision Services, we will pay billed charges directly to your Vision Care Provider. However, if you have already paid the Vision Care Provider, we will accept a request for payment submitted by you. 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 Rider, however if you submit a request for payment, you must file the claim in a format that contains all of the information we require, as described below.

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Reimbursement for Low Vision Services

To file a claim for reimbursement for Low Vision 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.

Submit the above information to us:

By mail:

Claims Department

P.O. Box 30978

Salt Lake City, UT 84130

By facsimile (fax):

248-733-6060

Section 4: Defined Terms for Pediatric Vision Care Services

The following definitions are in addition to those listed in *Section 9: Defined Terms* of the *Certificate*:

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 Network - 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 Rider in *Section 1: Benefits for Pediatric Vision Care Services.*

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