

[<sup>1</sup>Applies to SHOP Plans]

# [<sup>1</sup>Small Business Health Options Program Exchange (SHOP Exchange)]

## Group Policy

### UnitedHealthcare Insurance Company

[185 Asylum Street]

[Hartford, Connecticut 06103-3408]

[1-800-357-1371]

This Policy is entered into by and between UnitedHealthcare Insurance Company and the "Enrolling Group," as described in Exhibit 1.

When used in this document, the words "we," "us," and "our" are referring to UnitedHealthcare Insurance Company.

[<sup>1</sup>Applies to plans offered OFF the Exchange]

Upon our receipt of [<sup>1</sup>the Enrolling Group's signed application and] payment of the first Policy Charge, this Policy is deemed executed.

[<sup>1</sup>Applies to plans offered OFF the Exchange]

We agree to provide Benefits for Covered Health Services set forth in this Policy, including the attached *Certificate(s) of Coverage* and *Schedule(s) of Benefits*, subject to the terms, conditions, exclusions, and limitations of this Policy. [<sup>1</sup>The Enrolling Group's application is made a part of this Policy.]

This Policy replaces and overrules any previous agreements relating to Benefits for Covered Health Services between the Enrolling Group and us. The terms and conditions of this Policy will in turn be overruled by those of any subsequent agreements relating to Benefits for Covered Health Services between the Enrolling Group and us.

We will not be deemed or construed as an employer or plan administrator for any purpose with respect to the administration or provision of benefits under the Enrolling Group's benefit plan. We are not responsible for fulfilling any duties or obligations of an employer or plan administrator with respect to the Enrolling Group's benefit plan.

This Policy will become effective on the date specified in Exhibit 1 and will be continued in force by the timely payment of the required Policy Charges when due, subject to termination of this Policy as provided in Article 5.

When this Policy is terminated, as described in Article 5, this Policy and all Benefits under this Policy will end at 12:00 midnight on the date of termination except those available to Covered Persons under the *Extended Coverage for Total Disability* provision in *Section 4: When Coverage Ends* in the *Certificate of Coverage*.

This Policy is issued as described in Exhibit 1.

Issued By:

UnitedHealthcare Insurance Company

[Signature of authorized company officer]

[Title of authorized company officer]

## **Policy Table of Contents**

Article 1: Glossary of Defined Terms .....	3
Article 2: Benefits .....	3
Article 3: Premium Rates and Policy Charge.....	3
Article 4: Eligibility and Enrollment.....	4
Article 5: Policy Termination.....	5
Article 6: General Provisions.....	6
Exhibit 1.....	11
Exhibit 2.....	13
Exhibit 3 - Wellness Program.....	14

## Article 1: Glossary of Defined Terms

The terms used in this Policy have the same meanings given to those terms in *Section 9: Defined Terms* of the attached *Certificate(s) of Coverage*.

**Coverage Classification** - one of the categories of coverage described in Exhibit 2 for rating purposes (for example: Subscriber only, Subscriber and spouse, Subscriber and children, Subscriber and family).

**Material Misrepresentation** - any written communication or conduct, or combination of communication and conduct, that is untrue and is intended to create a misleading impression in the mind of another person. A misrepresentation is material if a reasonable person would attach importance to it in making a decision or determining a course of action, including but not limited to, the issuance of a policy or coverage under a policy, calculation of rates, or payment of a claim.

## Article 2: Benefits

Subscribers and their Enrolled Dependents are entitled to Benefits for Covered Health Services subject to the terms, conditions, limitations and exclusions set forth in the *Certificate(s) of Coverage* and *Schedule(s) of Benefits* attached to this Policy. Each *Certificate of Coverage* and *Schedule of Benefits*, including any Riders and Amendments, describes the Covered Health Services, required Copayments and Coinsurance, and the terms, conditions, limitations and exclusions related to coverage.

## Article 3: Premium Rates and Policy Charge

### 3.1 Premiums

Monthly Premiums payable by or on behalf of Covered Persons are specified in the *Schedule of Premium Rates* in Exhibit 2 of this Policy or in any attached *Notice of Change*.

[<sup>1</sup>Only applied when rating includes tobacco usage rating.]

We reserve the right to change the *Schedule of Premium Rates* as described in Exhibit 1 of this Policy. [<sup>1</sup>We also reserve the right to change the *Schedule of Premium Rates* if the *Schedule of Premium Rates* was based upon a Material Misrepresentation relating to tobacco use that resulted in the Premium rates being lower than they would have been if the Material Misrepresentation had not been made. Subject to the *Contestability of Coverage* provision below, we reserve the right to change the *Schedule of Premium Rates* for this reason retroactive to the effective date of the *Schedule of Premium Rates* that was based on the Material Misrepresentation.]

### 3.2 Computation of Policy Charge

The Policy Charge will be calculated based on the number of Subscribers in each Coverage Classification that we show in our records at the time of calculation. The Policy Charge will be calculated using the Premium rates in effect at that time. Exhibit 1 describes the way in which the Policy Charge is calculated.

### 3.3 Adjustments to the Policy Charge

[<sup>1</sup>Enter the appropriate number of days. <sup>2</sup>Applies to plans offered OFF the Exchange. <sup>3</sup>Applies to SHOP Plans.]

We may make retroactive adjustments for any additions or terminations of Subscribers or changes in Coverage Classification that are not reflected in our records at the time we calculate the Policy Charge. We will not grant retroactive credit for any change occurring more than [<sup>1</sup>30 - 90] days prior to the date we received notification of the change from the [<sup>2</sup>Enrolling Group] [<sup>3</sup>SHOP Exchange]. We also will not grant retroactive credit for any calendar month in which a Subscriber has received Benefits.

[<sup>2</sup>The Enrolling Group must notify us in writing within [<sup>1</sup>30 - 90] days of the effective date of enrollments, terminations, or other changes. The Enrolling Group must notify us in writing each month of any change in the Coverage Classification for any Subscriber.]

If taxes, fees, assessments, or other law change is made retroactively effective to this Policy and results in an increase in our cost of operation, we reserve the right to adjust the Policy Charge accordingly subject to required regulatory approval.

The Enrolling Group will continue to pay the Premium for any Subscribers and their Enrolled Dependents until we have received the notice of termination.

### **3.4 Payment of the Policy Charge**

*[<sup>1</sup>Applies to SHOP Plans. <sup>2</sup>Applies to plans offered OFF the Exchange.]*

The Policy Charge is payable to us by the [<sup>1</sup>SHOP Exchange from funds obtained by the] Enrolling Group as described under "Payment of the Policy Charge" in Exhibit 1. The first Policy Charge is due and payable on or before the effective date of this Policy. Subsequent Policy Charges are due and payable no later than the first day of each payment period, subject to the grace period described below and specified in item 6 of Exhibit 1, while this Policy is in force.

All payments shall be made in United States dollars, in immediately available funds, and shall be remitted to us at the address set forth in [<sup>2</sup>the Enrolling Group's application] [<sup>1</sup>Exhibit 1], or at such other address as we may from time to time designate in writing. [<sup>2</sup>The Enrolling Group agrees not to send us][<sup>1</sup>We will not accept] payments marked "paid in full", "without recourse", or similar language. In the event [<sup>2</sup>the Enrolling Group sends][<sup>1</sup>we receive] such a payment, we may accept it without losing any of our rights under this Policy and the Enrolling Group will remain obligated to pay any and all amounts owed to us.

A service charge will be assessed for any non-sufficient-fund check received in payment of the Policy Charge. All Policy Charge payments must be accompanied by supporting documentation that states the names of the Covered Persons for whom payment is being made.

### **3.5 Grace Period**

*[Must provide a minimum of a 30 day grace period.]*

A grace period of [30 - 90] days will be granted for the payment of any Policy Charge not paid when due. During the grace period, this Policy will continue in force.

*[<sup>1</sup>Include for plans that have a grace period option that exceeds 30 days]*

The Enrolling Group is liable for payment of the Policy Charge during the grace period [<sup>1</sup>limited to the first 30 days of the grace period]. If we receive written notice from the Enrolling Group to terminate this Policy during the grace period, we will collect a Policy Charge for the period beginning on the first day of the grace period until the date on which notice is received or the date of termination stated in the notice, whichever is later. [<sup>1</sup>However, such Policy Charge will not exceed the first 30 days of the grace period.]

This Policy terminates as described in Article 5.1 if the grace period expires and the past due Policy Charge remains unpaid.

## **Article 4: Eligibility and Enrollment**

### **4.1 Eligibility Conditions or Rules**

Eligibility conditions or rules for each class are stated in the corresponding Exhibit 2. The eligibility conditions stated in Exhibit 2 are in addition to those specified in *Section 3: When Coverage Begins* of the *Certificate of Coverage*.

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

#### **[4.2 Initial Enrollment Period]**

[Eligible Persons and their Dependents may enroll for coverage under this Policy during the Initial Enrollment Period as defined in *Section 9: Defined Terms* of the *Certificate of Coverage*. The Initial Enrollment Period is determined by the Enrolling Group.]

*[Applies to Shop Plans only]*

#### **[4.2 Enrollment Periods]**

[Eligible Persons and their Dependents may enroll for coverage under this Policy during the Initial Enrollment Period, the Annual Open Enrollment Period and/or the Open Enrollment period as provided and determined by the SHOP Exchange.]

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

#### **[4.3 Open Enrollment Period]**

[An Open Enrollment Period will be provided periodically for each class, as specified in the corresponding Exhibit 2. During an Open Enrollment Period, Eligible Persons may enroll for coverage under this Policy.]

#### **[4.4] Effective Date of Coverage**

The effective date of coverage for properly enrolled Eligible Persons and their Dependents is stated in Exhibit 2.

## **Article 5: Policy Termination**

### **5.1 Conditions for Termination of the Entire Policy**

This Policy and all Benefits for Covered Health Services under this Policy will automatically terminate on the earliest of the dates specified below except those Benefits available to Covered Persons under the *Extended Coverage for Total Disability* provision in *Section 4: When Coverage Ends* of the *Certificate of Coverage*:

*[<sup>1</sup>Include for plans that have a grace period option that exceeds 30 days] [<sup>2</sup>Applies for SHOP Plans.]*

- A. On the last day of the grace period if the Policy Charge remains unpaid. The Enrolling Group remains liable for payment of the Policy Charge for the period of time this Policy remained in force during the grace period. [<sup>1</sup>However, such Policy Charge will not exceed the first 30 days of the grace period.]
- B. On the date specified by the Enrolling Group [<sup>2</sup>or the SHOP Exchange]. The Enrolling Group may provide notice of termination during the grace period and request such termination to be effective upon the date such notice is received by us.
- C. On the date we specify, after at least 45 days prior written notice to the Enrolling Group, that this Policy is to be terminated due to the Enrolling Group's violation of the participation rules as shown in Exhibit 1.
- D. On the date we specify, after at least 31 days prior written notice to the Enrolling Group, that this Policy is to be terminated because the Enrolling Group performed an act, practice or omission that constituted fraud or made an intentional misrepresentation of a fact that was material to the execution of this Policy or to the provision of coverage under this Policy. In this case, we have the right to rescind this Policy back to either:
  - The effective date of this Policy.
  - The date of the act, practice or omission, if later.

This right to terminate and rescind the Policy expires two years after the effective date of the Policy.

- E. On the date we specify, after at least 90 days prior written notice to the Enrolling Group and each Covered Person, that this Policy is to be terminated because we will no longer issue this particular type of group health benefit plan within the applicable market.
- F. On the date we specify, after 30 working days prior notice to the applicable State authority, followed by at least 180 days prior written notice to the Enrolling Group and each Covered Person, that this Policy is to be terminated because we will no longer issue any employer health benefit plan within the applicable market.
- [G.] [<sup>2</sup>On the date we are decertified as a Qualified Health Plan.]

## 5.2 Payment and Reimbursement Upon Termination

Upon any termination of this Policy, the Enrolling Group is and will remain liable to us for the payment of any and all Premiums which are unpaid at the time of termination, including a pro rata portion of the Policy Charge for any period this Policy was in force during the grace period preceding the termination. If the Enrolling Group has made payments of any Premiums for a period of coverage beyond the date of Policy termination, we will refund such payments in full.

# Article 6: General Provisions

## 6.1 Entire Policy

[<sup>1</sup>Applies to Off Exchange plans only.]

This Policy, including the *Certificate(s) of Coverage*, the *Schedule(s) of Benefits*, [<sup>1</sup>the application of the Enrolling Group,] and any Amendments, Notices of Change, and Riders, constitute the entire Policy between the parties. All statements made by the Enrolling Group or by a Subscriber will, in the absence of fraud, be deemed representations and not warranties.

## 6.2 Dispute Resolution

The parties acknowledge that because this Policy affects interstate commerce, the *Federal Arbitration Act* applies. If the Enrolling Group wishes to seek further review of the decision or the complaint or dispute, it has the option to submit the decision, complaint or dispute to binding arbitration pursuant to the rules of the *American Arbitration Association*.

Arbitration will take place in Hartford County, Connecticut.

If the Enrolling Group elects binding arbitration, the matter must be submitted to binding arbitration within one year of the date notice of the dispute was received. The arbitrators will have no power to award any punitive or exemplary damages or to vary or ignore the provisions of this Policy, and will be bound by controlling law.

## 6.3 Contestability of Coverage

The following rules apply:

- The Policy may not be contested, except for nonpayment of Premiums, after it has been in force for two years from its date of issue;
- 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 two years during the Covered Person's lifetime.
- Absent fraud, each statement made by the Enrolling Group or a Covered Person is considered to be a representation and not a warranty; and

- A statement made to effectuate insurance may not be used to avoid the insurance or reduce Benefits under the Policy unless:
  - The statement is contained in a written instrument signed by the Enrolling Group or a Covered Person, and
  - A copy of the statement is given to the Enrolling Group or a Covered Person..

#### **6.4 Amendments and Alterations**

Amendments to this Policy are effective 31 days after we send written notice to the Enrolling Group. Riders are effective on the date we specify. Other than changes to Exhibit 2 stated in a Notice of Change to Exhibit 2, no change will be made to this Policy unless made by an Amendment or a Rider which is signed by one of our authorized executive officers and such authorization is endorsed on the Policy or attached to and made a part of the Policy. No agent has authority to change this Policy or to waive any of its provisions.

*[<sup>1</sup>Applies to plans offered OFF the Exchange.] [<sup>2</sup>Applies for SHOP Plans.]*

#### **6.5 Relationship between Parties**

The relationships between us and Network providers, and relationships between us and Enrolling Groups, are solely contractual relationships between independent contractors. Network providers and Enrolling Groups are not our agents or employees, nor are we or any of our employees an agent or employee of Network providers or Enrolling Groups.

The relationship between a Network provider and any Covered Person is that of provider and patient. The Network provider is solely responsible for the services provided by it to any Covered Person. The relationship between any Enrolling Group and any Covered Person is that of employer and employee, Dependent, or any other category of Covered Person described in the Coverage Classifications specified in this Policy.

[<sup>1</sup>The Enrolling Group is solely responsible for enrollment and Coverage Classification changes (including termination of a Covered Person's coverage) and for the timely payment of the Policy Charges.]

[<sup>2</sup>The Enrolling Group is solely responsible for timely payment of the Policy Charges to the SHOP Exchange.]

#### **6.6 Records**

The Enrolling Group must furnish us with all information and proofs which we may reasonably require with regard to any matters pertaining to this Policy. We may at any reasonable time inspect:

- All documents furnished to the Enrolling Group by an individual in connection with coverage.
- The Enrolling Group's payroll.
- Any other records pertinent to the coverage under this Policy.

By accepting Benefits under this Policy, each Covered Person authorizes and directs any person or institution that has provided services to him or her, to furnish us or our designees any and all information and records or copies of records relating to the health care services provided to the Covered Person. 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 any and all records concerning health care services which are necessary to implement and administer the terms of this Policy including records necessary for appropriate medical review and quality assessment or as we are required by law or regulation.

During and after the term of this Policy, we and our related entities may use and transfer the information gathered under this Policy for research and analytic purposes.

## **6.7 Administrative Services**

The services necessary to administer this Policy and the Benefits provided under it will be provided in accordance with our standard administrative procedures or those standard administrative procedures of our designee. If the Enrolling Group requests that administrative services be provided in a manner other than in accordance with these standard procedures, including requests for non-standard reports, the Enrolling Group must pay for such services or reports at the then current charges for such services or reports.

We may offer to provide administrative services to the Enrolling Group for certain wellness programs including, but not limited to, fitness programs, biometric screening programs and wellness coaching programs.

*[Remove when group is not subject to ERISA.]*

## **[6.8] [Employee Retirement Income Security Act (ERISA)]**

[When this Policy is purchased by the Enrolling Group to provide benefits under a welfare plan governed by the federal *Employee Retirement Income Security Act* 29 U.S.C., 1001 et seq., we will not be named as, and will not be, the plan administrator or the named fiduciary of the welfare plan, as those terms are used in ERISA.]

## **[6.9] Examination of Covered Persons**

In the event of a question or dispute concerning Benefits for Covered Health Services, we may reasonably require that a Network Physician, acceptable to us, examine the Covered Person at our expense.

*[<sup>1</sup>Enter the appropriate number of days.]*

## **[6.10] Clerical Error**

Clerical error will not deprive any individual of Benefits under this Policy or create a right to Benefits. Failure to report enrollments will not be considered a clerical error and will not result in retroactive coverage for Eligible Persons. Any Benefit continued due to a clerical error, in the absence of fraud or material misrepresentation, may only be prospectively terminated. Due to this, the Enrolling Group may not submit a retroactive adjustment when Premium is paid and coverage is continued in force beyond the date it was scheduled to terminate according to the terms of the Policy. In this situation, the coverage will remain in force for the period for which Premium was paid and no adjustment will be made. However, failure to report the termination of coverage, due to a delay in administrative record keeping when the Subscriber has not contributed towards the Premium, will not continue the coverage for a Covered Person beyond the date it is scheduled to terminate according to the terms of this Policy. Upon discovery of a clerical error, any necessary appropriate adjustment in Premiums will be made. However, we will not grant any such adjustment in Premiums or coverage to the Enrolling Group for more than [130 - 90] days of coverage prior to the date we received notification of the clerical error.

## **[6.11] Workers' Compensation Not Affected**

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

## **[6.12] Conformity with Law**

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

### **[6.13] Notice**

When we provide written notice regarding administration of this Policy to an authorized representative of the Enrolling Group, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Enrolling Group is responsible for giving notice to Covered Persons on a timely basis.

Any notice sent to us under this Policy and any notice sent to the Enrolling Group must be addressed as described in Exhibit 1.

### **[6.14] Continuation Coverage**

We agree to provide Benefits under this Policy for those Covered Persons who are eligible to continue coverage under federal or state law, as described in *Section 4: When Coverage Ends* of the *Certificate of Coverage*.

We will not provide any administrative duties with respect to the Enrolling Group's compliance with federal or state law. All duties of the plan sponsor or plan administrator remain the sole responsibility of the Enrolling Group, including but not limited to notification of COBRA and/or state law continuation rights and billing and collection of Premium.

[<sup>1</sup>Applies to plans offered OFF the Exchange.] [<sup>2</sup>Applies to SHOP Plans.]

### **[6.15] Certification of Coverage Forms**

As required by the federal *Health Insurance Portability and Accountability Act of 1996 (HIPAA)*, we will produce certification of coverage forms for Covered Persons who lose coverage under this Policy. [<sup>1</sup>The Enrolling Group agrees to provide us with all necessary eligibility and termination data.] Certification of coverage forms will be based on eligibility and termination data that [<sup>1</sup>the Enrolling Group provides] [<sup>2</sup>is provided] to our eligibility systems in accordance with our data specifications, and which is available in our eligibility systems as of the date the form is generated. The certification of coverage forms will only include periods of coverage that we administer under this Policy.

### **[6.16] Subscriber's Individual Certificate**

We will issue *Certificate(s) of Coverage, Schedule(s) of Benefits*, and any attachments to the Enrolling Group for delivery to each covered Subscriber. The *Certificate(s) of Coverage, Schedule(s) of Benefits*, and any attachments will show the Benefits and other provisions of this Policy. In addition, you may have access to your *Certificate(s) of Coverage* and *Schedule(s) of Benefits* online at [[www.myuhc.com](http://www.myuhc.com)].

### **[6.17] System Access**

The term "systems" as used in this provision means our systems that we make available to the Enrolling Group to facilitate the transfer of information in connection with this Policy.

#### **System Access**

We grant the Enrolling Group the nonexclusive, nontransferable right to access and use the functionalities contained within the systems, under the terms set forth in this Policy. The Enrolling Group agrees that all rights, title and interest in the systems and all rights in patents, copyrights, trademarks and trade secrets encompassed in the systems will remain ours. In order to obtain access to the systems, the Enrolling Group will obtain, and be responsible for maintaining, at no expense to us, the hardware, software and Internet browser requirements we provide to the Enrolling Group, including any amendments to those requirements. The Enrolling Group is responsible for obtaining an internet service provider or other access to the Internet.

The Enrolling Group will not:

- Access systems or use, copy, reproduce, modify, or excerpt any of the systems documentation provided by us in order to access or utilize systems, for purposes other than as expressly permitted under this Policy.

- Share, transfer or lease its right to access and use systems, to any other person or entity which is not a party to this Policy.

The Enrolling Group may designate any third party to access systems on its behalf, provided the third party agrees to these terms and conditions of systems access and the Enrolling Group assumes joint responsibility for such access.

### **Security Procedures**

The Enrolling Group will use commercially reasonable physical and software-based measures, and comply with our security procedures, as may be amended from time to time, to protect the system, its functionalities, and data accessed through systems from any unauthorized access or damage (including damage caused by computer viruses). The Enrolling Group will notify us immediately if any breach of the security procedures, such as unauthorized use, is suspected.

### **System Access Termination**

We reserve the right to terminate the Enrolling Group's system access:

- On the date the Enrolling Group fails to accept the hardware, software and browser requirements provided by us, including any amendments to the requirements.
- Immediately on the date we reasonably determine that the Enrolling Group has breached, or allowed a breach of, any applicable provision of this Policy. Upon termination of this Policy, the Enrolling Group agrees to cease all use of systems, and we will deactivate the Enrolling Group's identification numbers and passwords and access to the system.

# Exhibit 1

1. **Parties.** The parties to this Policy are UnitedHealthcare Insurance Company and \_\_\_\_\_, the Enrolling Group.
2. **Effective Date of this Policy.** The effective date of this Policy is 12:01 a.m. on [\_\_\_\_\_, 20\_\_] in the time zone of the Enrolling Group's location.

<sup>[1]</sup>ERISA groups.]

<sup>[2]</sup>Non-ERISA groups.]

3. **Place of Issuance.** We are delivering this Policy in the State of Maryland. [<sup>1</sup>This Policy is governed by ERISA. To the extent that state law applies, the laws of the State of Maryland are the laws that govern this Policy.] [<sup>2</sup>The laws of the State of Maryland are the laws that govern this Policy.]

<sup>[1]</sup>Applies to off Exchange plans. <sup>2</sup>Only applied when rating includes tobacco usage rating. <sup>3</sup>Applies to SHOP plans.]

4. **Premiums.** We reserve the right to change the Schedule of Premium Rates specified in Exhibit 2, after a 45-day prior written notice on the first anniversary of the effective date of this Policy [<sup>1</sup>specified in the application or on any monthly due date thereafter,] or on any date the provisions of this Policy are amended. [<sup>2</sup>Subject to the *Contestability of Coverage* provision above, we also reserve the right to change the Schedule of Premium Rates, retroactive to the effective date, if a Material Misrepresentation relating to tobacco use has resulted in a lower schedule of rates.] [<sup>3</sup>Premiums for the Enrolling Group are set for the Plan Year.]
5. **Computation of Policy Charge.** A pro rata Premium, calculated on the number of days Covered Persons are actually covered under this Policy, will be charged for Covered Persons whose effective date of coverage falls on a date other than the first of the month or for Covered Persons whose coverage is terminated on a date other than the first of the month.

<sup>[1]</sup>Applies to off Exchange plans. <sup>2</sup>Applies to SHOP plans. <sup>3</sup>Select the appropriate payment basis.]

6. **Payment of the Policy Charge.** The Policy Charge is payable to us in advance by the [<sup>1</sup>Enrolling Group] [<sup>2</sup>SHOP Exchange from funds obtained by the Enrolling Group] [<sup>3</sup>on a [monthly] [quarterly] [semi-annual] [annual] basis] [as follows: \_\_\_\_\_].
7. **Minimum Participation Requirement.** 75% of Eligible Persons excluding spousal waivers must be enrolled for coverage under this Policy. Minimum participation requirements are not applied when the Enrolling Group applies for coverage during the period that begins November 15 and extends through December 15 of any year.
8. **Notice.** Any notice sent to us under this Policy must be addressed to:

\_\_\_\_\_  
(Name of Issuing Entity)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(City, State, Zip)

Any notice sent to the Enrolling Group under this Policy must be addressed to:

\_\_\_\_\_  
(Enrolling Group)

(Address)

---

(City, State, Zip)

*[Enrolling group policy number is included here.]*

[9]. [\_\_\_\_ Enrolling Group Number]

## Exhibit 2

### 1. Class Description.

All Eligible Employees.

*[<sup>1</sup>Applies to plans offered OFF the Exchange.] [<sup>2</sup>Applies to SHOP plans.]*

2. **Eligibility.** The eligibility rules are [<sup>1</sup>established by the Enrolling Group] [<sup>2</sup>verified by the SHOP Exchange]. [<sup>1</sup>The following eligibility rules are in addition to the eligibility rules specified in the Employer Application and/or in *Section 3: When Coverage Begins* of the Certificate of Coverage:

*[Variable to add waiting or probationary period timeframe as determined by the enrolling group. The waiting period for an otherwise eligible individual to enroll will not exceed 90 days, in accordance with § 2708 of the Affordable Care Act.]*

- A. The waiting or probationary period for newly Eligible Persons is as follows:

[\_\_\_\_\_]]

*[<sup>1</sup>Applies to plans offered OFF the Exchange. <sup>2</sup>Include timeframes agreed upon between the enrolling group and us.]*

- [3.] [<sup>1</sup>Open Enrollment Period. An Open Enrollment Period of at least 31 days will be provided by the Enrolling Group during which Eligible Persons may enroll for coverage. The Open Enrollment Period will be provided on [<sup>2</sup>an annual basis] [<sup>2</sup>a quarterly basis] [<sup>2</sup>\_\_\_\_\_].

*[<sup>1</sup>Insert the actual effective date. For SHOP plans this will always be the 1st day of the Plan Year.*

*<sup>2</sup>Always include for SHOP plans. The other options may be included for Off Exchange plans. <sup>3</sup>Include when effective date is last day of the waiting period. <sup>4</sup>Included when effective date is the 1st day of the month following the waiting period. <sup>5</sup>Included when effective date is the date the person joins the enrolling group. <sup>6</sup>Included when effective date is the 1st day of the month following the date the person joins the enrolling group. <sup>7</sup>Included when effective date is another date, as determined by the enrolling group.]*

- [4.] **Effective Date for Eligible Persons.** The effective date of coverage for Eligible Persons who are eligible on the effective date of this Policy is [<sup>1</sup>\_\_\_\_\_].

For an Eligible Person who becomes eligible after the effective date of this Policy, his or her effective date of coverage is [<sup>2</sup>the date verified by the SHOP Exchange][<sup>3</sup>The day following the last day of the required waiting period.] [<sup>4</sup>the first day of the month following the last day of the required waiting period.] [<sup>5</sup>the date the Eligible Person joins the Enrolling Group.] [<sup>6</sup>the first day of the month following the date the Eligible Person joins the Enrolling Group.][<sup>7</sup>as determined by the Enrolling Group, \_\_\_\_\_.] Any required waiting period will not exceed 90 days.

- [5.] **Schedule of Premium Rates.**

Monthly Premiums payable by or on behalf of Covered Persons are specified in the *Cost Summary* detailed through the new business premium confirmation process and renewal package.

## Exhibit 3 - Wellness Program

*[<sup>1</sup>Include the appropriate option as selected by the Enrolling Group.]*

The Enrolling Group agrees to promote a wellness program that provides a health assessment that may be completed by each [<sup>1</sup>Covered Person age 18 years and older][<sup>1</sup>Subscriber and Enrolled Dependent spouse age 18 years and older] on a voluntary basis. Written feedback will be provided to each [<sup>1</sup>Covered Person age 18 years and older][<sup>1</sup>Subscriber and Enrolled Dependent spouse age 18 years and older] who completes a health assessment. The feedback will provide information to help lower the risks identified in the completed health assessment.

[<sup>1</sup>Applies to SHOP Plans]

# [<sup>1</sup>Small Business Health Options Program (SHOP Exchange)] Certificate of Coverage UnitedHealthcare Insurance Company

## Certificate of Coverage is Part of Policy

[<sup>1</sup>Include for Off Exchange plans only]

[<sup>2</sup>Include for SHOP Plans only]

This *Certificate of Coverage (Certificate)* is part of the Policy that is a legal document between UnitedHealthcare Insurance Company and the Enrolling Group to provide Benefits to Covered Persons, subject to the terms, conditions, exclusions and limitations of the Policy. We issue the Policy based on [<sup>1</sup>the Enrolling Group's application and] payment of the required Policy Charges [<sup>2</sup>by the SHOP Exchange from funds obtained by the Enrolling Group.]

In addition to this *Certificate* the Policy includes:

- The *Group Policy*.
- The *Schedule of Benefits*.
- [<sup>1</sup>The Enrolling Group's application.]
- Riders.
- Amendments.

You can review the Policy at the office of the Enrolling Group during regular business hours.

## Changes to the Document

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

No one can make any changes to the Policy unless those changes are in writing.

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, modify, withdraw or add Benefits, or to terminate 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 specified in the Policy. Coverage under the Policy will begin at 12:01 a.m. and end at 12:00 midnight in the time zone of the Enrolling Group's location. The Policy will

remain in effect as long as the Policy Charges are paid when they are due, subject to termination of the Policy.

We are delivering the Policy in the State of Maryland. The Policy is governed by ERISA unless the Enrolling Group is not an employee welfare benefit plan as defined by ERISA. To the extent that state law applies, the laws of the State of Maryland are the laws that govern the Policy.

# Introduction to Your Certificate

We are pleased to provide you with this *Certificate*. This *Certificate* and the other Policy documents describe your Benefits, as well as your rights and responsibilities, under the Policy.

## How to Use this Document

We encourage you to read your *Certificate* and any attached Riders and/or Amendments carefully.

We especially encourage you to review the Benefit limitations of this *Certificate* by reading the attached *Schedule of Benefits* along with *Section 1: Covered Health Services* and *Section 2: Exclusions and Limitations*. You should also carefully read *Section 8: General Legal Provisions* to better understand how this *Certificate* and your Benefits work. You should call us if you have questions about the limits of the coverage available to you.

Many of the sections of this *Certificate* are related to other sections of the document. You may not have all of the information you need by reading just one section. We also encourage you to keep your *Certificate* and *Schedule of Benefits* and any attachments in a safe place for your future reference.

If there is a conflict between this *Certificate* and any summaries provided to you by the Enrolling Group, this *Certificate* will control.

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

## Information about Defined Terms

Because this *Certificate* 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 *Section 9: Defined Terms*. You can refer to *Section 9: Defined Terms* as you read this document to have a clearer understanding of your *Certificate*.

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare 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*.

## Don't Hesitate to Contact Us

Throughout the document you will find statements that encourage you to contact us for further information. Whenever you have a question or concern regarding your Benefits, please call us using the telephone number for *Customer Care* listed on your ID card. It will be our pleasure to assist you.

# Your Responsibilities

## Be Enrolled and Pay Required Contributions

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

[<sup>1</sup>Applies to plans offered OFF the Exchange. <sup>2</sup>Applies to SHOP plans.]

- Your enrollment must be in accordance with [<sup>1</sup>the Policy issued to your Enrolling Group, including] the eligibility requirements [<sup>2</sup>as verified by the SHOP Exchange].
- You must qualify as a Subscriber or his or her Dependent as those terms are defined in *Section 9: Defined Terms*.

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

## Be Aware this Benefit Plan Does Not Pay for All Health Services

Your right to Benefits is limited to Covered Health Services. The extent of this Benefit plan's payments for Covered Health Services and any obligation that you may have to pay for a portion of the cost of those Covered Health Services is set forth in the *Schedule of Benefits*.

## Decide What Services You Should Receive

Care decisions are between you and your Physicians. 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 care to you. 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 Services require prior authorization. In general, Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. However, if you choose to receive Covered Health Services from a non-Network provider, you are responsible for obtaining prior authorization before you receive the services. For detailed information on the Covered Health Services that require prior authorization, please refer to the *Schedule of Benefits*.

## Pay Your Share

You must pay a Copayment and/or Coinsurance for most Covered Health Services. These payments are due at the time of service or when billed by the Physician, provider or facility. Copayment and Coinsurance amounts are listed in the *Schedule of Benefits*. You must also pay any amount that exceeds Eligible Expenses.

## Pay the Cost of Excluded Services

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

## **Show Your ID Card**

You should show your identification (ID) card every time you request health services. If you do not show your ID card, the provider may fail to bill the correct entity for the services delivered, and any resulting delay may mean that you will be unable to collect any Benefits otherwise owed to you. 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 Services from a non-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described in *Section 5: How to File a Claim*.

# Our Responsibilities

## Determine Benefits

We make administrative decisions regarding whether this Benefit plan 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 have the discretion to do 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 delegate this discretionary authority to other persons or entities that may provide administrative services for this Benefit plan, such as claims processing. The identity of the service providers and the nature of their services may be changed from time to time in our discretion. In order to receive Benefits, you must cooperate with those service providers.

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

We pay Benefits for Covered Health Services as described in *Section 1: Covered Health 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 Services. It also means that not all of the health care services you receive may be paid for (in full or in part) by this Benefit plan.

## Pay Network Providers

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

## Pay for Covered Health Services Provided by Non-Network Providers

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

## Review and Determine Benefits in Accordance with our Reimbursement Policies

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

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

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), our reimbursement policies are applied to provider billings. We share our reimbursement policies with Physicians and other providers in our Network through our provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. However, non-Network providers are not subject to this

prohibition, and may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed, however this provision does not apply to an on-call Physician, a Hospital-based Physician, or an ambulance service provider as defined under Maryland law, who has accepted an assignment of Benefits. An on-call Physician, Hospital-based Physician, or ambulance service provider as defined under Maryland law, who has accepted an assignment of Benefits will be paid in accordance with the payment methodology as required in Maryland law. You may obtain copies of our reimbursement policies for yourself or to share with your non-Network Physician or provider by going to [[www.myuhc.com](http://www.myuhc.com)] or by calling *Customer Care* at the telephone number on your ID card.

## **Offer Health Education Services to You**

From time to time, 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 participate in the programs, but we recommend that you discuss them with your Physician.

## **Certificate of Coverage Table of Contents**

<b>Section 1: Covered Health Services.....</b>	<b>[9]</b>
<b>Section 2: Exclusions and Limitations .....</b>	<b>[23]</b>
<b>Section 3: When Coverage Begins.....</b>	<b>[27]</b>
<b>Section 4: When Coverage Ends .....</b>	<b>[35]</b>
<b>Section 5: How to File a Claim .....</b>	<b>[40]</b>
<b>Section 6: Questions, Complaints and Appeals .....</b>	<b>[42]</b>
<b>Section 7: Coordination of Benefits .....</b>	<b>[50]</b>
<b>Section 8: General Legal Provisions.....</b>	<b>[55]</b>
<b>Section 9: Defined Terms .....</b>	<b>[60]</b>

# Section 1: Covered Health Services

## Benefits for Covered Health Services

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

- The health care service or supply is only a Covered Health Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Service in *Section 9: Defined Terms*.) The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness substance use disorder, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Service under the Policy.
- Covered Health Services are received 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*.
- Covered Health Services are received 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 Services is a Covered Person and meets all eligibility requirements specified in the Policy or is receiving Benefits under the *Extended Coverage for Total Disability* provision in *Section 4: When Coverage Ends*.

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

- The amount you must pay for these Covered Health Services (including any deductible, Copayment and/or Coinsurance).
- Any limit that applies to these Covered Health Services (including visit, day and dollar limits on services).
- Any limit that applies to the amount you are required to pay in a year (Out-of-Pocket Maximum).
- Any responsibility you have for obtaining prior authorization or notifying us.

[<sup>1</sup>Include the appropriate option as selected by the Enrolling Group.]

Benefits include a health assessment that may be completed by each [<sup>1</sup>Covered Person age 18 years and older][<sup>1</sup>Subscriber and Enrolled Dependent spouse age 18 years and older] on a voluntary basis. Written feedback will be immediately provided to each [<sup>1</sup>Covered Person age 18 years and older][<sup>1</sup>Subscriber and Enrolled Dependent spouse age 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."*

### 1. Ambulance Services

Ambulance Services to or from the nearest Hospital where needed medical services can appropriately be provided.

Benefits include Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance) to the nearest Hospital where Emergency Health Services can be performed.

Non-Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as we determine appropriate) between facilities when the transport is any of the following:

- From a non-Network Hospital to a Network Hospital.
- To a Hospital that provides a higher level of care that was not available at the original Hospital.
- To a more cost-effective acute care facility.
- From an acute facility to a sub-acute setting.

## **2. 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, immunoglobulin and albumin.

## **3. Case Management Services**

Any other services approved through our case management program.

## **4. 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.

## **5. Controlled Clinical Trials**

Routine patient care costs incurred during participation in a qualifying clinical trial for the treatment of:

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

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

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

Routine patient care costs for qualifying clinical trials include:

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

Routine costs for clinical trials do not include:

- The Experimental Service or investigational service 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 satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

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

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

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - *National Institutes of Health (NIH)*. (Includes *National Cancer Institute (NCI)*.)
  - *Centers for Disease Control and Prevention (CDC)*.
  - *Agency for Healthcare Research and Quality (AHRQ)*.
  - *Centers for Medicare and Medicaid Services (CMS)*.
  - A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA)*.
  - A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.
  - The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
    - ◆ Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*.
    - ◆ Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation is conducted under an investigational new drug application reviewed by the *U.S. Food and Drug Administration*.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (*IRBs*) before participants are enrolled in the trial. We may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Policy.

## 6. 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.

## 7. Detoxification Services

Detoxification services in a Hospital or Related Institution.

## 8. Diabetes Treatment, Equipment and Supplies

Benefits are provided for diabetes treatment, equipment and supplies.

Diabetic equipment includes glucose monitoring equipment and insulin pumps for an insulin-using Covered Person as part of a treatment plan prescribed by the Covered Person's Health Care Practitioner, and such Benefits will be provided under the *Durable Medical Equipment* Benefit below. Diabetes supplies include insulin syringes and needles, and testing strips for glucose monitoring equipment for Covered Persons using insulin as part of a treatment plan prescribed by the Covered Person Health Care Practitioner, and will be provided under the *Prescription Drug Product* Benefit described below.

For the purpose of this Benefit, "insulin-using" means a Covered Person who uses insulin as part of a treatment plan prescribed by the Covered Person's Physician.

## 9. Durable Medical Equipment

Durable Medical Equipment including nebulizers, peak flow meters, prosthetic devices such as leg, arm, back, or neck braces, artificial legs, arms, or eyes, and the training necessary to use these prosthesis.

Durable Medical Equipment must meet each of the following criteria:

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered Durable Medical Equipment.
- Not of use to a person in the absence of a disease or disability.

Benefits under this section include Durable Medical Equipment provided to you by a Physician.

If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the equipment that meets the minimum specifications for your needs.

Benefits for prosthetic devices under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body.

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 are available for repairs and replacement, except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices.

## **10. Emergency Health Services**

Services provided on an outpatient basis in a Hospital or an Alternate Facility that are required to stabilize or initiate treatment in an Emergency.

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

## **11. Family Planning Services**

Family planning services include the following:

- Prescription contraceptive drugs or devices;
- Coverage for the insertion or removal of contraceptive devices;
- Medically Necessary examination associated with the use of contraceptive drugs or devices; and
- Voluntary sterilization.

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*, or for Preventive Care Medications, under *Prescription Drug Products*.

## **12. Habilitative Services**

Except for habilitative services provided in early intervention and school services, habilitative services for the treatment of congenital or genetic birth defects.

For the purpose of this Benefit, "habilitative services" means services, including occupational therapy, physical therapy, and speech therapy, for the treatment of Covered Persons with congenital and genetic birth defects to enhance the Covered Person's ability to function.

For Covered Person age 0-19 years old, Benefits for habilitative services for the treatment of congenital or genetic birth defects, include services for cleft lip and cleft palate, orthodontics, oral surgery, otologic, and audiological therapy.

## **13. Hearing Aids**

Hearing aids, for Covered Persons ages 0-18 years, required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

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

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

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

## 14. Home Health Care Services

Home health care services are provided as an alternative to otherwise Covered Health Services in a Hospital, Related Institution or Skilled Nursing Facility.

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.

In accordance with state law, home health care services are also available for the following:

*[Delete if plan design qualifies as a high-deductible health plan under federal law issued to support an HSA.]*

- One home visit and an additional home visit when prescribed by a Physician for a mother and newborn child following discharge from a Hospital prior to a 48 hour Inpatient Stay for an uncomplicated delivery or 96 hours for an uncomplicated cesarean delivery. Such newborn home visits are not subject to any [<sup>1</sup>deductible,] Copayment or Coinsurance payments shown in the *Schedule of Benefits*.
- One home visit when prescribed by a Physician for a mother and newborn child following discharge from a Hospital after a 48 hour Inpatient Stay for an uncomplicated delivery or 96 hours for an uncomplicated cesarean delivery. Such a home visit is not subject to any [<sup>1</sup>deductible,] Copayment or Coinsurance payments shown in the *Schedule of Benefits*.
- For the purpose of this Benefit, "home health care" means the continued care and treatment of a Covered Person in the home if: 1) the institutionalization of the Covered Person in a Hospital or Related Institution or skilled nursing facility would otherwise have been required if home health care were not provided; and 2) the plan of treatment covering the home health care service is established and approved in writing by the Health Care Practitioner.

## 15. Hospice Care Services

For the purpose of this Benefit, "hospice care services" means the following items and services provided to a terminally ill Covered Person by, or by others under arrangement made by a Hospice Program under a written plan (for providing such care to such Covered Person) established and periodically reviewed by the Covered Person's attending Physician and by the Medical Director.

1. Nursing care provided by or under the supervision of a registered professional nurse;
2. Physical or occupational therapy or speech-language pathology;
3. Medical social services under the direction of a Physician;
4. Services of a home health aide and homemaker services;

5. Medical supplies, including drugs and biologicals, and the use of medical appliances;
6. Physician services;
7. Short-term inpatient care, including both respite care and procedures necessary for pain control and acute and chronic system management, in an inpatient facility, but such respite care may be provided only on an intermittent, non-routine and occasional basis and may not be provided consecutively over longer than five (5) days;
8. Counseling, including dietary counseling, with respect to care of the terminally ill Covered Person and adjustment to his or her death.

The care and services described above in numbers (1) and (4) above may be provided on a twenty-four (24) hour continuous basis only during periods of crisis and only as necessary to maintain the terminally ill individual at home.

## **16. 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*.

## **17. Inpatient Hospital Services**

Services provided during an Inpatient Stay in a Hospital.

Benefits include 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

## **18. 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.

## **19. Medical Office Services**

Care in medical offices for treatment of Sickness or Injury.

Benefits include services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is free-standing, located in a clinic or located in a Hospital.

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

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

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing which is ordered by the Physician and authorized in advance by us.

Benefits under this section include allergy injections.

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

Benefits under this section include lab, radiology/X-ray or other diagnostic services performed in the Physician's office. Benefits under this section do not include CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services.

Covered Health Services received at an Urgent Care Center are described below under *Urgent Care Center Services*.

## **20. Mental Health and Substance Use Disorder Services - Inpatient**

Mental Health Services and Substance Use Disorder Services include those received on an inpatient basis in a Hospital, Related Institution, Residential Treatment Facility, or entity licensed by the *Department of Health and Mental Hygiene* to provide Residential Crisis Services.

Benefits include the following services provided on inpatient basis:

- Diagnostic evaluations and assessment (Including psychological and neuropsychological testing for diagnostic purposes).
- Treatment planning.
- Referral services.
- Medication evaluation and management (pharmacotherapy).
- Individual, family, therapeutic group and provider-based case management services.
- Treatment and counseling, including individual and group therapy visits
- Crisis intervention and stabilization for acute episodes and Residential Crisis Services.
- Services at a Residential Treatment Facility.
- Residential Crisis Services.
- Electroconvulsive therapy.
- Inpatient professional fees.

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*.

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

We encourage you to contact the Mental Health/Substance Use Disorder Designee for referrals to providers and coordination of care.

### **Special Mental Health Programs and Services**

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Designee may become available to you as a part of your Mental Health Services and Substance Use Disorder Benefit. The Mental Health and Substance Use Disorder Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your Mental Illness or substance use disorder which may not otherwise

be covered under the Policy. You must be referred to such programs through the Mental Health/Substance Use Disorder Designee, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.

## **21. Mental Health and Substance Use Disorder Services - Outpatient**

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

Benefits include the following services provided on an outpatient basis:

- Diagnostic evaluations and assessment (Including psychological and neuropsychological testing for diagnostic purposes). This includes outpatient diagnostic tests provided and billed by a licensed mental health and substance use disorder practitioner and outpatient diagnostic tests provided and billed by a laboratory, Hospital or other covered facility.
- Treatment planning.
- Referral services.
- Medication evaluation and management (pharmacotherapy).
- Individual, family, therapeutic group and provider-based case management services.
- Treatment and counseling, including individual and group therapy visits
- Crisis intervention and stabilization for acute episodes and Residential Crisis Services.
- Partial Hospitalization/Day Treatment
- Intensive Outpatient Treatment.
- Electroconvulsive therapy.

Benefits for outpatient services at an Emergency room are provided as described above under *Emergency Health Services*. Benefits for detoxification services are provided as described above under *Detoxification Services*.

The Mental Health/Substance Use Disorder Designee determines coverage for all levels of care.

We encourage you to contact the Mental Health/Substance Use Disorder Designee for referrals to providers and coordination of care.

### **Special Mental Health Programs and Services**

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

## **22. 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.

### **23. Outpatient Hospital Services**

Services provided on an outpatient basis at a Hospital or Alternate Facility or in Physician's office.

Benefits include, but are not limited to:

- Diagnostic and therapeutic scopic procedures and related services.
- Surgery and related services.
- Therapeutic treatments

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

Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Examples of therapeutic treatments include dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

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

### **24. Outpatient Laboratory and Diagnostic Services**

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility.

Benefits include bone mass measurement testing for diagnostic and treatment purposes. Benefits for bone mass measurement performed for prevention of osteoporosis is provided under *Preventive Care Services*.

Benefits include CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services provided in a Physician's office.

### **25. Outpatient Rehabilitative Services**

Short-term outpatient rehabilitation services, limited to:

- Physical therapy.
- Occupational therapy.
- Speech therapy.
- Cardiac rehabilitation therapy. Benefits include continuous EKG telemetric monitoring during exercise, EKG rhythm strip with interpretation, Physician's revision of exercise prescription, and follow up examination for Physician to adjust medication or change regimen.
- Pulmonary rehabilitation therapy.

For the purpose of this Benefit, "outpatient rehabilitation services" means occupational therapy, speech therapy, physical therapy, cardiac rehabilitation therapy and pulmonary rehabilitation therapy, provided to a Covered Person not admitted to a Hospital or Related Institution.

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

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

Benefits can be denied or shortened for Covered Persons who are not expected to progress further in goal-directed rehabilitation services or all rehabilitation goals have previously been met. Cardiac rehabilitation therapy and pulmonary rehabilitation therapy provided as maintenance programs are excluded as described in *Section 2: Exclusions and Limitations*.

Benefits are provided for Medically Necessary speech therapy in adult Covered Persons who have lost speech due to Sickness or Injury, or for the treatment of a congenital or genetic defect. Benefits are provided for Medically Necessary speech therapy in Enrolled Dependent children who have lost speech or who have never gained speech due to Sickness, Injury or diagnosed developmental disorder.

## **26. Pregnancy - Maternity Services**

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

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

We also have special prenatal programs to help during Pregnancy. They are completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify us during the first trimester, but no later than one month prior to the anticipated childbirth. It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs designed to achieve the best outcomes for you and your baby.

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

- 48 hours for the mother and newborn child following an uncomplicated 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:

- 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.

## **27. Prescription Drug Products**

Prescription drug products include insulin, birth control drugs, Specialty Prescription Drug Products and Preventive Care Medications.

Benefits are provided for up to a 90-day supply of maintenance medication dispensed in a single dispensing.

However, Benefits provided for up to a 90-day supply of maintenance medication in a single dispensing is not required for the first prescription of a maintenance medication or a change in a prescription of a maintenance medication.

For the purpose of this Benefit, "maintenance medication" means a drug anticipated to be required for 6 months or more to treat a chronic condition.

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.

If a Tier-2 or Tier-3 prescription drug product is prescribed and the Covered Person selects a Tier-2 or Tier-3 prescription drug product when a Tier-1 prescription drug product that is chemically the same is available, the Covered Person will pay any applicable Copayment or Coinsurance, plus the difference between the price of the Tier-2 or Tier-3 prescription drug product and Tier-1 prescription drug product.

## 28. Preventive Care Services

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

- Evidence-based items or services, inclusive of current recommendations for breast cancer, that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*. Note that recommendations of the *United States Preventive Services Task Force* regarding breast cancer screening, mammography and prevention issued in or around November 2009 are not considered to be current.
- Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*. 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, not described above, as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*. Preventive care Benefits defined under the *Health Resources and Services Administration* requirement include the cost of renting one breast pump at a time per Pregnancy in conjunction with childbirth. 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.
  - Duration of a rental.
  - Timing of an acquisition.

## 29. Reconstructive Breast Surgery and Breast Prosthesis

Reconstructive breast surgery and prosthesis, including Benefits for all stages of reconstructive breast surgery performed on a non-diseased breast to establish symmetry with the diseased breast when reconstructive breast surgery is performed on the diseased breast; and physical complications of all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the Covered Person. Benefits are provided for breast prosthesis and breast reconstruction on the non-diseased breast to achieve symmetry regardless of the patient's insurance status at the time of the mastectomy or the time lag between the mastectomy and reconstruction.

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. Reconstructive breast surgery includes augmentation mammoplasty, reduction mammoplasty and mastopexy.

## 30. Skilled Nursing Facility Services

Skilled Nursing Facility services provided as an alternative to Medically Necessary inpatient Hospital services.

Please note that Benefits are available only when Skilled Nursing Facility services are provided as an alternative to a Medically Necessary Inpatient Stay in a Hospital and are not Custodial Care.

Skilled care is skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true:

- It 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.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

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

## 31. 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
- 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.

### **32. Transplantation Services**

Benefits are provided for solid organ transplants and other non-solid organ transplant procedures. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service, and is not an Experimental Service.

Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Policy.

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.

We have specific guidelines regarding Benefits for transplant services. Contact us at the telephone number on your ID card for information about these guidelines.

### **33. Urgent Care Center Services**

Covered Health 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 *Medical Office Services*.

## 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 Services, except as may be specifically provided for in *Section 1: Covered Health Services* or through a Rider to the Policy.

### Benefit Limitations

When Benefits are limited within any of the Covered Health Service categories described in *Section 1: Covered Health Services*, those limits are stated in the corresponding Covered Health Service category in the *Schedule of Benefits*. 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, examination, 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.
10. Practitioner, Hospital, or clinical services related to radial keratotomy, myopic keratomileusis, and surgery which involves 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.
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 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, including any extension of Benefits.
17. Surgery or related services for cosmetic purposes 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, failure to keep a scheduled visit, or completion of any form.
22. Inpatient admissions primarily for diagnostic studies, unless authorized by us.
23. The purchase, examination, or fitting of hearing aids and supplies, and tinnitus maskers. This exclusion does not hearing aids for minor children for which Benefits are provided as described in *Section 1: Covered Health Services under Hearing Aids*.
24. 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 Services under Transplantation Services*.
25. Except for Emergency Health Services, services received while the Covered Person is outside the United States.
26. Immunizations related to foreign travel.
27. Unless otherwise specified in *Section 1: Covered Health Services*, dental work or treatment which includes hospital or professional care in connection with:
  - (a) The operation or treatment for the fitting or wearing of dentures,
  - (b) Orthodontic care or malocclusion,
  - (c) Operations on or for treatment of or to the teeth or supporting tissues of the teeth, except for removal of tumors and cysts or treatment of injury to natural teeth due to an accident if the treatment is received within 6 months of the accident; and
  - (d) Dental implants.
28. 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*.
29. 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.
30. 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.
31. Inpatient admissions primarily for physical therapy, unless authorized by us.
32. Treatment leading to or in connection with transsexualism, or sex changes or modifications, including but not limited to surgery.
33. Treatment of sexual dysfunction not related to organic disease.

34. Services that duplicate benefits provided under federal, State, or local laws, regulations, or programs,
35. Nonhuman organs and their implantation.
36. Nonreplacement fees for blood and blood products.
37. Lifestyle improvements, including nutrition counseling, or physical fitness programs, unless included as a Covered Service.
38. Wigs or cranial prosthesis.
39. Weekend admission charges, except for emergencies and maternity, unless authorized us.
40. Outpatient orthomolecular therapy, including nutrients, vitamins, and food supplements.
41. 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;
42. 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.
43. Services for conditions that State or local laws, regulations, ordinances, or similar provisions require to be provided in a public institution.
44. 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.
45. Physical examinations required for obtaining or continuing employment, insurance, or government licensing.
46. Nonmedical ancillary services such as vocational rehabilitation, employment counseling, or educational therapy.
47. Private hospital room, unless authorized by us.
48. Private Duty Nursing, unless authorized by us.
49. Treatment for Mental Health or Substance Use Disorder Services for the following:
  - Services by pastoral or marital counselors
  - Therapy for sexual problems.
  - Treatment for learning disabilities or intellectual disabilities.
  - Telephone therapy.
  - 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.
50. Cardiac rehabilitation therapy and pulmonary rehabilitation therapy services provided at a place of service that is not equipped and approved to provide such therapies.
51. Cardiac rehabilitation therapy and pulmonary rehabilitation therapy provided as maintenance programs. Maintenance programs consist of activities that preserve the individual's present level of function and prevent regression of that function. Maintenance begins when therapeutic goals of a

treatment plan have been achieved, or when no additional progress is apparent or expected to occur.

52. 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*.

For Benefits other than prescription contraceptive coverage, we will grant a request for an exclusion from a Benefit under this Policy for an Enrolling Group, that is a bona fide religious organization, and such Benefit is in conflict with the Enrolling Group's religious beliefs and practices.

For prescription contraceptive coverage, we will grant a request for exclusion of contraceptive prescription drug products under the Policy for an Enrolling Group that meets the requirements of a religious organization and maintains a self-certification as described under 45 CFR §147.131.

## Section 3: When Coverage Begins

### How to Enroll

*[<sup>1</sup>Applies to plans offered OFF the Exchange. <sup>2</sup>Applies to SHOP plans]*

Eligible Persons must complete [<sup>1</sup>an enrollment form] [<sup>2</sup>a SHOP Exchange application]. [<sup>1</sup>The Enrolling Group will give the necessary forms to you. The Enrolling Group will then submit the completed forms to us, along with any required Premium.] We will not provide Benefits for health services that you receive before your effective date of coverage.

### If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Related Institution on the day your coverage begins, we will pay Benefits for Covered Health Services that you receive on or after your first day of coverage related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Policy. These Benefits are subject to any prior carrier's obligations under state law or contract.

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

### Who is Eligible for Coverage

*[<sup>1</sup>Applies to plans offered OFF the Exchange. <sup>2</sup>Applies to SHOP plans]*

The [<sup>1</sup>Enrolling Group] [<sup>2</sup>SHOP Exchange] determines who is eligible to enroll under the Policy and who qualifies as a Dependent.

*[<sup>1</sup>Applies to SHOP plans]*

### Eligible Person

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

Eligible Persons must reside within the United States.

If both spouses are Eligible Persons of the Enrolling 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 actually 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.

### When to Enroll and When Coverage Begins

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 Enrolling 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 identified in the Policy if we receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible to enroll.]

### **[Open Enrollment Period]**

[The Enrolling Group determines the Open Enrollment Period. 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 Enrolling Group; or
- Change enrollment in a health benefit plan offered by the Enrolling Group to a different health benefit plan offered by the Enrolling Group.

Coverage begins on the date identified by the Enrolling Group if we receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible to enroll.]

### **[New Eligible Persons]**

[Coverage for a new Eligible Person and his or her Dependents begins on the date agreed to by the Enrolling Group if we receive the completed enrollment form and any required Premium within 31 days of the date the new Eligible Person first becomes eligible.]

### **[Adding New Dependents]**

*[<sup>1</sup>Applies when plan design selected by the Enrolling Group provides coverage for domestic partners.]*

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

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

**In addition, 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.

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.
- In cases where the insuring parent does not enroll the child as a Dependent, permit the non-insuring parent, child support enforcement agency, or *Department of Health and Mental Hygiene* 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:**

Coverage for all other Dependents begins on the date of the event if we receive the completed enrollment form and any required Premium within 31 days of the event that makes the new Dependent eligible. If you fail to 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]**

*[Applies only if plan design the Enrolling Group selects provides coverage for domestic partners.]*

[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:

- Birth.
- Legal adoption.

- Placement for adoption.
- Marriage.
- [<sup>1</sup>Registering a Domestic Partner.]

A special enrollment period also applies for an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period if the following are true:

- 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)*. Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date of determination of subsidy eligibility.
- The Eligible Person and/or Dependent lose minimum essential coverage. Loss of minimum essential coverage does not include the loss of coverage due to:
  - 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 fact).
- 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 Enrolling 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 or death). However, a special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan was terminated for cause, or because premiums were not paid on a timely basis.
  - 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 Eligible Person and/or Dependent no longer lives or works in an HMO service area if no other benefit option is available. However, a special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan was terminated for cause, or because premiums were not paid on a timely basis.
  - The plan no longer offers benefits to a class of individuals that include the Eligible Person and/or Dependent. However, a special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan was terminated for cause, or because premiums were not paid on a timely basis.
  - An Eligible Person and/or Dependent incurs a claim that would exceed a lifetime limit on all benefits. For purpose of the "date of the event" below, the date of the event for exceeding the lifetime limit on all benefits would be the date a claim is denied for exceeding such lifetime limit. However, a special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan was terminated for cause, or because premiums were not paid on a timely basis.

- 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.

When an event takes place (for example, a birth, marriage or determination of eligibility for state subsidy), coverage begins on the date of the event if we receive the completed enrollment form and any required Premium within 31 days of the event unless otherwise noted above.

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 immediately 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 31 days of the date coverage under the prior plan ended.]

*[Below Enrollment provisions applies to SHOP Exchange Plans]*

### **[Initial Enrollment Period]**

[The Initial Enrollment Period and effective dates of coverage for the SHOP Exchange will be established by the SHOP Exchange.]

### **[Annual Open Enrollment Period]**

[For years 2015 and later, the SHOP Exchange provides an Annual Open Enrollment Period of at least 30 days. The Annual Open Enrollment Period must take place before the end of the Enrolling Group's Plan Year. The SHOP Exchange will provide notice to an Eligible Person of the Annual Open Enrollment Period in advance of such period.

During the Annual Open Enrollment Period, Eligible Persons can:

- Enroll themselves and their Dependents.
- Discontinue enrollment in a health benefit plan offered by the Enrolling Group; or
- Change enrollment in a health benefit plan offered by the Enrolling Group to a different health benefit plan offered by the Enrolling Group. However, Eligible Persons who are Indians may change plans once per month.

Coverage begins on the first day of the Plan Year.]

### **[Open Enrollment Period]**

[The SHOP Exchange will provide an Open Enrollment Period of at least 30 days for employees that become Eligible Persons outside of the Initial Enrollment Period or the Annual Open Enrollment Period.]

### **[Special Enrollment Period]**

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

The SHOP Exchange will allow Eligible Persons and/or Dependents to enroll in or change from one Qualified Health Plan to another as a result of the following triggering events:

- Eligible Person and/or Dependent loses minimum essential coverage. Losing minimum essential coverage includes the following: 1) Loss of eligibility for coverage (including legal separation, divorce or death); 2) 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); and 3) In the case of COBRA continuation coverage, the coverage ended.

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

- Failure to pay Premiums on a timely basis, including COBRA premium prior to the expiration of COBRA coverage; 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).
- Eligible Persons gains a Dependent or becomes a Dependent through marriage, birth, adoption or placement for adoption. A Dependent spouse may enroll through special enrollment due to birth or adoption of a child, provided the spouse is otherwise eligible for coverage.
- Eligible Person's enrollment or non-enrollment in a Qualified Health Plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the SHOP Exchange or HHS, or its instrumentalities 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.
- Eligible Person and/or Dependent enrolled in the SHOP Exchange adequately demonstrate to the SHOP Exchange that the qualified plan substantially violated a material provision of its contract in relation to the Eligible Person and/or Dependent.
- Eligible Person and/or Dependent enrolled in the SHOP Exchange gains access to new Qualified Health Plans due to a permanent move.
- 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;
- 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.
- Eligible Person and/or Dependent is enrolled in an employer-sponsored health benefit plan that is not qualifying coverage in an eligible employer-sponsored plan and is allowed to terminate existing coverage.
- Eligible Person and/or Dependent loses eligibility for coverage under a Medicaid plan under Title XIX of the Social Security Act or a state child health plan under Title XXI of the Social Security Act; or becomes eligible for assistance, with respect to coverage under the SHOP Exchange, under a Medicaid plan or state child health plan, including any waiver or demonstration project conducted under or in relation to a Medicaid plan or a state child health plan.

**Effective Dates for Special Enrollment:**

- For birth, adoption, or placement of adoption, coverage is effective on the date of birth, adoption, or placement for adoption.
- For marriage [, registering a Domestic Partner] or loss of minimum essential coverage, coverage is effective on the first day of the following month.
- For cases when; 1) the enrollment or non-enrollment was unintentional, inadvertent or erroneous and the result of error by the SHOP Exchange or HHS; 2) the qualified plan substantially violated a material provision of its contract; or 3) the individual meets other exceptional circumstances, coverage is effective on the date of the triggering event, or 1) the first day of the following month when selection is received between the first and fifteenth day of any month, or 2) the first day of the second following month if the selection is received between the sixteenth and the last day of the month.
- For all other triggering events: When selection is made between the first and fifteenth day of any month, coverage is effective on the first day of the following month. When selection is made between the sixteenth and the last day of the month, coverage is effective the first day of the second following month.

**Length of Special Enrollment Periods:**

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

- A special enrollment period of 31 days for birth, adoption, placement for adoption, [or ]marriage [or Registering a Domestic Partner] .
- A special enrollment period of 60 days before the end of the Eligible Person's and/or Dependent's coverage under an employer sponsored plan when an Eligible Person and/or Dependent is enrolled in an employer-sponsored health benefit plan that is not qualifying coverage in and an eligible employer-sponsored plan is allowed to terminate existing coverage.
- 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.]

### **[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.
- In cases where the insuring parent does not enroll the child as a Dependent, permit the non-insuring parent, child support enforcement agency, or *Department of Health and Mental Hygiene* to apply for 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.]

## Section 4: When Coverage Ends

### General Information about When Coverage Ends

We may discontinue this Benefit plan and/or all similar benefit plans at any time for the reasons explained in the Policy, as permitted by law.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date, 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 Services that you received before the date on which your coverage ended. However, once your coverage ends, we will not pay claims for any health services received after that date, except as noted below under *Extended Coverage for Total Disability*.

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

Please note that for Covered Persons who 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]

### [Events Ending 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 the event the entire Policy ends, the Enrolling Group is responsible for notifying you that your coverage has ended.

[Throughout this section, select appropriate option for "date" or "last day of the calendar month in which".]

- **You Are No Longer Eligible**

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

- **We Receive Notice to End Coverage**

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

- **Subscriber Retires or Is Pensioned**

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

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

[Applies to SHOP plans only.]

## [Events Ending Your Coverage

When the following happens, we will provide written notice with the specific reason for termination at least 30 days prior to your last day of coverage.

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 or Decertify as a Qualified Health Plan**  
Your coverage ends when the SHOP Exchange has made notification to you as required under Federal law in the event of decertification.
- **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 the Covered Person by the SHOP Exchange, unless the Covered Person requests an earlier termination.
- **Non-Payment of Premium**  
Your coverage ends on the last day of any applicable grace period. Otherwise your coverage ends on the last paid date of coverage.
- **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.]

## Other Events Ending Your Coverage

When the following happens, we will provide 30 days advance written notice to the Subscriber that coverage will end on the date we identify in the notice:

- **Fraud or Intentional Misrepresentation of a Material Fact**  
You committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include false information relating to another person's eligibility or status as a 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 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 terminated, 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 the limiting age if all of the following are true regarding the Enrolled Dependent child:

- Is not able to be self-supporting because of mental or physical incapacity that originated before the Enrolled Dependent child attained the limiting age.
- Depends mainly on the Subscriber for support.
- Is unmarried.

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

We will ask you to furnish us with proof of the medical certification of incapacitation within 31 days of the date coverage would otherwise have ended because the child reached a certain age. Before we agree to this extension of coverage for the child, we may require that a Physician chosen by us examine the child. We will pay for that examination.

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

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

## **Extended Coverage for Total Disability**

When a Covered Person is Totally Disabled on the date that coverage terminates, a temporary extension of coverage will be granted.

The temporary extension will continue until (a) the day the Total Disability ends; or (b) 12 months from the date coverage under the Policy would otherwise have terminated whichever occurs first. No Premium will be charged for this coverage extension.

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

## **Continuation of Coverage**

If your coverage ends under the Policy, you may be entitled 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 Enrolling Groups that are subject to the terms of COBRA. You can contact your plan administrator to determine if your Enrolling Group is subject to the provisions of COBRA.

If you selected 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 Enrolling 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.

We are not obligated to provide continuation coverage to you if the Enrolling Group or its plan administrator fails to perform its responsibilities under federal law. Examples of the responsibilities of the Enrolling 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 Enrolling 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 Enrolling 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 Enrolling Group provide an election notification form. Within 14 days of the receipt of the request, the Enrolling 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 Enrolling 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 Enrolling 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 Enrolling 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 Enrolling Group. In this case coverage will be effective retroactive to the date of the applicable change in status.
- (2) 30 days after the date the insured employee becomes eligible for coverage under a group contract issued to another employer, if the insured employer 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 Enrolling 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 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*;
- 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 Enrolling Group with a signed and sworn affidavit verifying all facts in the termination statement.

### **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 Enrolling 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 Enrolling Group provide an election notification form. Within 14 days of the receipt of the request, the Enrolling 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 Enrolling 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 Enrolling 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 the group contract, that is written on an expense-incurred basis or is with a health maintenance organization.
- The date the Covered Persons 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.

## Section 5: How to File a Claim

### If You Receive Covered Health Services from a Network Provider

We pay Network providers directly for your Covered Health Services. If a Network provider bills you for any Covered Health Service, contact us. However, you are responsible for meeting any applicable deductible and for paying any required Copayments and Coinsurance to a Network provider at the time of service, or when you receive a bill from the provider.

### If You Receive Covered Health Services from a Non-Network Provider

When you receive Covered Health Services from a non-Network provider, you are responsible for requesting payment from us. 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 should submit a request for payment of Benefits within 90 days after the date of service. 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, if the request is furnished as soon as reasonably possible and, except in the absence of a legal capacity of the claimant, not later than one year from the time the request for payment is otherwise required. 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 insurance 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. When filing a claim for Outpatient Prescription Drug Benefits, your claims should be submitted to:

[Name of Pharmacy Benefit Manager]  
[Address of Pharmacy Benefit Manager]  
[City, State and Zip Code]

### Payment of Benefits

We will pay Benefits within 30 days after we receive your request for payment that includes all required information. If a Subscriber provides written authorization to allow this, all or a portion of any Eligible Expenses due to a provider may be paid directly to the provider instead of being paid to the Subscriber.

But we will not reimburse third parties that have purchased or been assigned benefits by Physicians or other providers.

Benefits will be paid to you unless either of the following is true:

- The provider notifies us that your signature is on file, assigning benefits directly to that provider.
- You make a written request at the time you submit your claim.

We may refuse to directly reimburse a non-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 non-Network provider; or
- You paid the non-Network provider the amount due at the time of your service.

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.

## Section 6: Questions, Complaints and Appeals

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

### What to Do if You Have a Question

Contact *Customer Care* at the telephone number shown on your ID card. *Customer Care* representatives are available to take your call during regular business hours, Monday through Friday.

### What to Do if You Have a Complaint

Contact *Customer Care* at the telephone number shown on your ID card. *Customer Care* 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 *Customer Care* representative can provide you with the appropriate address.

If the *Customer Care* representative cannot resolve the issue to your satisfaction 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.

## Adverse Decisions, Adverse Decision Grievances and Adverse Decision Complaints

### Defined Terms

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 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 care service.
- "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, or the Covered Person remaining seriously mentally ill with symptoms that cause the Covered Person to be in danger to self or others.
- "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.
- "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 a your behalf, may file a complaint with the Commissioner without first filing a 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; or
- Your complaint is based on one of the exceptions as described below under *Internal Adverse Decision Grievance Process*.

## 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 the adverse decision involves an urgent condition for which services have not already been rendered, or is described above under *Complaints*, or unless it is under one of the other circumstances outlined below. For retrospective denials (denials on health services which have already been rendered), a compelling reason may not be shown. If the adverse decision by us involves a compelling reason for which services have not been rendered, you, your representative, or your health care provider may address your complaint directly to the Insurance Commissioner without first directing it to us.

## Adverse Decisions

We will not make an adverse decision retrospectively regarding preauthorized or approved Covered Health 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 Services whereby the preauthorization or approval for such Covered Health 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 verbally communicated to you, your representative, or your health care provider.

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

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

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

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

- Details concerning the specific factual basis for the denial in clear, understandable language;
- The specific criteria or guidelines on which the decision is based;
- The name, business address and direct telephone number of the Medical Director who made the decision;
- Written details of our internal 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; and
- 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 60 days of receipt of our adverse decision letter unless the adverse decision is a retrospective denial in which case you have up to 180 days from the date of receipt to file an adverse decision grievance.
- 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. Unless written permission has been given, 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. Unless written permission has been given, 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 we need additional information in order 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 assist you, your representative, or the health care provider in gathering the necessary medical records without further delay. If no additional information is available or is not submitted to us, we will render a decision based on the available information.
- Except as described under the first two bullets in the *Complaints* provision above, for retrospective denials, you, your representative, or your health care provider on your behalf, must file 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 the due date of the response to the adverse benefit determination.
- In addition to the first two bullets of the *Complaints* provision above, for prospective denials, you, your representative, or your health care provider on your behalf, may file an adverse decision complaint with the Insurance Commissioner (see below) without first filing an adverse decision grievance with us, if you, your representative, or your health care provider can demonstrate that the adverse decision concerns a compelling reason for which a delay would result in loss of life, serious impairment to a bodily function, serious dysfunction of a bodily organ or the Covered Person remaining seriously mentally ill with symptoms that cause the Covered Person to be in danger to self or others.

### **Expedited Review in Emergency Cases**

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

The procedure listed below will be followed:

- If the health care provider filed the adverse decision grievance, he or she will determine whether the basis for an emergency case or expedited review exists. If the Covered Person, or the Covered Person's representative, filed the adverse decision grievance, we, in consultation with the health care provider, will determine whether the basis for an emergency case or expedited review exists. In either case, the determination will be based on the above definition of "emergency case".
- We will render a verbal grievance decision to an adverse decision grievance filed by you, your representative, or your health care provider on your behalf, within 24 hours of receipt of the adverse decision grievance. Within one day after the verbal grievance decision has been communicated, we will send notice in writing of any adverse decision 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 an adverse decision complaint directly with the Insurance Commissioner. If we uphold our decision to deny coverage for the Covered Health 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 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, Maryland 21202

410-528-1840 or 1-877-261-8807 (toll free)

Fax number: 410-576-6571

E-mail: [consumer@oag.state.md.us](mailto:consumer@oag.state.md.us)]

### **Medical Directors**

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

UnitedHealthcare Insurance Company

[4 Taft Court

Rockville, Maryland 20850

301-762-8205/ 1-800-544-2853]

### **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]

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

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

Health Education and Advocacy Unit

[200 St. Paul Place, 16th Floor

Baltimore, Maryland 21202

Telephone number: (410) 528-1840

Fax number: (410) 576-6571

E-mail: [consumer@oag.state.md.us](mailto:consumer@oag.state.md.us)]

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

- For an emergency case, written notice of the Insurance Commissioner's final decision will be sent to the Covered Person, the Covered Person's representative and/or the health care provider within 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.

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

### **Assistance from State Agencies**

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

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

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]

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

Office of the Attorney General

Health Education and Advocacy Unit

[200 St. Paul Place, 16th Floor

Baltimore, Maryland 21202

Telephone number: (410) 528-1840

Fax number: (410) 576-6571

E-mail: [consumer@oag.state.md.us](mailto:consumer@oag.state.md.us)]

### **Coverage and Appeal Decisions**

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

- "Appeal" means a protest filed by a Covered Person, a Covered Person's representative or a health care provider with us under our internal appeal process regarding a coverage decision concerning a Covered Person.

- "Appeal decision" means a final determination made by us that arises from an appeal filed with us under our appeal process regarding a coverage decision concerning a Covered person.
- "Coverage decision" means:
  - an initial determination by us or our representative that results in non-coverage of a health care service;
  - a determination by us that an individual is not eligible for coverage under the Policy;
  - any determination by us that results in the rescission of an individual's coverage under the Policy.

A coverage decision includes a nonpayment of all or any part of a claim.

A coverage decision does not include:

- ◆ an adverse decision as described above; or
- ◆ a pharmacy inquiry.
- "Health Advocacy Unit" means the Health Education and Advocacy Unit in the Division of Consumer Protection of the Office of the Attorney General.
- "Pharmacy inquiry" means an inquiry submitted by a pharmacist or pharmacy on behalf of a Covered Person to us or a pharmacy benefits manager at the point of sale about the scope of pharmacy coverage, pharmacy benefit design, or formulary, if available, under the Policy.
- "Your representative" means an individual who has been authorized by you to file an appeal or a complaint on your behalf.

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

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

Website address: [www.oag.state.md.us](http://www.oag.state.md.us)]

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 or your representative, or the health care provider gives sufficient information and supporting documentation in the complaint that demonstrates an urgent medical condition exists.

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

- A medical condition, including a physical condition, a mental condition, or a dental condition, where the absence of medical attention within 72 hours could reasonably be expected by an individual, acting on our behalf, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, to result in:
  - Placing the Covered Person's life or health in serious jeopardy;
  - The inability of the Covered Person to regain maximum function;
  - Serious impairment to bodily function;
  - Serious dysfunction of any bodily organ or part; or
  - The Covered Person remaining seriously mentally ill with symptoms that cause the Covered Person to be a danger to self or others; or
- A medical condition, including a physical condition, a mental health condition, or a dental condition, where the absence of medical attention within 72 hours in the opinion of a health care provider with knowledge of the Covered Person's medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the coverage decision.

## Section 7: 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 Coordination of Benefits Applies

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. 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. 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.

### Definitions

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

- A. A Plan is any of the following that provides benefits or services for medical, pharmacy or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
1. Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.
  2. Plan does not include: hospital indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; intensive care policies; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; medical benefits under group or individual automobile contracts or coverage under other federal governmental plans, unless permitted by law.

For purposes of this section, "intensive care policy" means a health insurance policy that provides benefits only when treatment is received in that specifically designated facility of a hospital that provides the highest level of care and which is restricted to those patients who are physically, critically ill or injured.

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

- B. This Plan 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. 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 is a health care expense, including deductibles, coinsurance and copayments, 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 in accordance with a 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 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 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.

## **Order of Benefit Determination Rules**

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

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

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

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

- C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.
- D. Each Plan determines its order of benefits using the first of the following rules that apply:
1. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.
  2. Dependent Child Covered Under More Than One Coverage Plan. Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:
    - a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
      - (1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
      - (2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.
    - b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:
      - (1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary Plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.
      - (2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.
      - (3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.

- (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.
3. Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.
4. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.
5. Longer or Shorter Length of Coverage. The Plan that covered the person longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.
6. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

## **Effect on the Benefits of This Plan**

- A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, 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.

## **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.

## Section 8: General Legal Provisions

### Your Relationship with Us

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how we interact with your Enrolling Group's Benefit plan and how it may affect you. We help finance or administer the Enrolling Group's Benefit plan 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 Enrolling Group's Benefit plan will cover or pay for the health care that you may receive. The plan pays for Covered Health Services, which are more fully described in this *Certificate*.
- The plan may not pay for all treatments you or your Physician may believe are necessary. If the plan does not pay, you will be responsible for the cost.

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.

### Our Relationship with Providers and Enrolling Groups

The relationships between us and Network providers and Enrolling Groups are solely contractual relationships between independent contractors. Network providers and Enrolling Groups are not our agents or employees. Neither we nor any of our employees are agents or employees of Network providers or the Enrolling Groups.

We do not provide health care services or supplies, nor do we practice medicine. Instead, 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, but does not assure the quality of the services provided. They are not our employees nor do we have any other relationship with Network providers such as principal-agent or joint venture. We are not liable 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 Enrolling Group's Benefit plan. We are not responsible for fulfilling any duties or obligations of an employer with respect to the Enrolling Group's Benefit plan.

The Enrolling 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).

[<sup>1</sup>Include for plans offered Off the Exchange. <sup>2</sup>Include for SHOP Exchange plans.]

- The timely payment of the Policy Charge [<sup>1</sup>to us][<sup>2</sup>to the SHOP Exchange].
- [<sup>1</sup>Notifying you of the termination of the Policy.]

[<sup>2</sup>We are responsible for notifying you of the termination of the Policy.]

When the Enrolling 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 Enrolling 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*.

## Your Relationship with Providers and Enrolling Groups

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

- You are responsible for choosing your own provider.
- You are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any deductible and any amount that exceeds Eligible Expenses.
- You are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.
- You must decide if any provider treating you is right for you. This includes Network providers you choose and providers to whom you have been referred.
- You must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and the Enrolling 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 Enrolling Group, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Enrolling Group is responsible for giving notice to you.]

## Statements by Enrolling Group or Subscriber

All statements made by the Enrolling Group or by a Subscriber shall, in the absence of fraud, be deemed representations and not warranties. We will not use any statement made by the Enrolling Group to void the Policy after it has been in force for a period of two years. Once the Policy has been in effect for two years, it may not be terminated, 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 Enrolling Group or the Subscriber, and
- A copy of the statement is given to the Enrolling Group, Subscriber or beneficiary of the Subscriber.

## Incentives to Providers

We pay Network providers through various types of contractual arrangements, some of which 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.

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 contact 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; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

## **Rebates and Other Payments**

We may receive rebates for certain drugs that are administered to you in your home or in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet any applicable deductible. We do not pass these rebates on to you, nor are they applied to any deductible or taken into account in determining your Copayments or Coinsurance.

## **Interpretation of Benefits**

We have the sole and exclusive discretion to do all of 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 delegate this discretionary 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, in our discretion, offer Benefits for services that would otherwise not be Covered Health 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.

## **Administrative Services**

We may, in our sole discretion, arrange for various persons or entities to provide administrative services in regard to the Policy, 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 in our sole discretion. 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 reserve the right, in our sole discretion and without your approval, to change, interpret, modify, withdraw or add Benefits or terminate 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 hereby amended to conform to the minimum requirements of such statutes and regulations.

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. All of the following conditions apply:

- Amendments to the Policy are effective 31 days after we send written notice to the Enrolling Group.
- Riders are effective on the date we specify.
- 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.

## **Information and Records**

We may use your individually identifiable health information to administer the Policy and pay claims, to identify procedures, products, or services that you may find valuable, and 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 your 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. 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 any and all records concerning health care services which are necessary to implement and administer the terms of the Policy, for appropriate medical review or quality assessment, or as we are required to do 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 we recommend that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from 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 necessary. Our designees have the same rights to this information as we have.

## **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.

## **Workers' Compensation not Affected**

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

## **Subrogation and Reimbursement**

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

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

Any proceeds of settlement or judgment shall be held in trust by the Covered Person for our benefit under these subrogation provisions.

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

## Refund of Overpayments

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

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person. 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, the Covered Person agrees to help us get the refund when requested.

When the refund is due from the Covered Person and the Covered Person does not promptly refund the full amount, we may reduce the amount of any future Benefits for the Covered Person that are payable under the Policy. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

## Limitation of Action

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

## Entire Policy

[1Include for Off Exchange Plans only]

The Policy issued to the Enrolling Group, including this *Certificate*, the *Schedule of Benefits*<sup>[1]</sup>, the Enrolling Group's application,] any Riders and/or Amendments, and any Notices of Change, constitutes the entire Policy. 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.

## Section 9: Defined Terms

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

- Surgical services.
- Emergency Health Services.
- Mental Health Services or Substance Use Disorder Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

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

**Annual Deductible** - for Benefit plans that have an Annual Deductible, this is the amount of Eligible Expenses you must incur for Covered Health Services per year before we will begin paying for Benefits. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to payment of an Annual Deductible and for details about how the Annual Deductible applies.

[Applies to SHOP plans]

**[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.]

**Autism Spectrum Disorders** - a group of neurobiological disorders that includes Autistic Disorder, Rhett's Syndrome, Asperger's Disorder, Childhood Disintegrated Disorder and Pervasive Development Disorders Not Otherwise Specified (PDDNOS).

**Benefits** - your right to payment for Covered Health Services that are available under the Policy. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of the Policy, including this *Certificate*, the *Schedule of Benefits* and any attached Riders and/or Amendments.

**Coinsurance** - the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health 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.

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

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

- The applicable Copayment.
- The Eligible Expense.

**Cosmetic Procedures** - procedures or services that change or improve appearance without significantly improving physiological function, as determined by us.

**Covered Health Service(s)** - those health services, including services, supplies, or pharmaceutical products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Service in this *Certificate* under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
- Not otherwise excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.

**Covered Person** - either the Subscriber or an Enrolled Dependent, but this term applies only while the person is enrolled under the Policy. References to "you" and "your" throughout this *Certificate* are references to a Covered Person.

**Custodial Care** - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

[<sup>1</sup>Applies when group purchases domestic partner coverage.]

**Dependent** - the Subscriber's legal spouse or a child of the Subscriber or the Subscriber's spouse. [<sup>1</sup>All references to the spouse of a Subscriber shall include a Domestic Partner.] The term child includes any of the following:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- 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.

The definition of Dependent is subject to the following conditions and limitations:

- A Dependent includes any child listed above under 26 years of age.
- A Dependent includes an unmarried dependent child age 26 or older who is or becomes incapacitated and dependent upon the Subscriber.

The Subscriber must reimburse us for any Benefits that we pay for a child at a time when the 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.

A Dependent also includes a child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. We are responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order*.

**Designated Facility** - a facility that has entered into an agreement with us, or with an organization contracting on our behalf, to render Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within your geographic area. The fact that a Hospital is a Network Hospital does not mean that it is a Designated Facility.

**Designated Physician** - a Physician that we've identified through our designation programs as a Designated provider. A Designated Physician may or may not be located within your geographic area. The fact that a Physician is a Network Physician does not mean that he or she is a Designated Physician.

*[Applies when plan design selected by the Enrolling Group includes benefits for 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.

*[<sup>1</sup>Include if Enrolling Group requires proof of domestic partnership.]*

- [<sup>1</sup>We may require the Domestic Partners to furnish documents 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;
- 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.]

*[<sup>2</sup>Applies if group requires signed affidavit.]*

[<sup>2</sup>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 Enrolling Group who, at the option of the Enrolling Group, may include:

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

**Eligible Expenses** - for Covered Health Services, incurred while the Policy is in effect or while the Covered person is receiving Benefits under the *Extended Coverage for Total Disability* provision in *Section 4: When Coverage Ends*. Eligible Expenses are determined by us as stated below and as detailed in the *Schedule of Benefits*.

Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines. We develop our reimbursement policy guidelines, in our discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

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

[<sup>1</sup>Applies to plan offered OFF the Exchange. <sup>2</sup>Applies to SHOP plans]

**Eligible Person** - an Eligible Employee of the Enrolling Group or other person whose connection with the Enrolling Group meets the eligibility requirements specified [<sup>1</sup>in both the application and the Policy] [<sup>2</sup>by the SHOP Exchange]. An Eligible Person must reside within the United States.

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

- 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 Health Services** - with respect to an Emergency:

- A medical screening examination (as required under *section 1867 of the Social Security Act, 42 U.S.C. 1395dd*) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency, and
- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under *section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3))*.

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

[Applies to plan offer OFF the Exchange]

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

*[Applies to SHOP plans only.]*

**[Enrolling Group** - a small employer that 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 Enrolling Group, some of all of its Part-Time Employees, provided that the Enrolling 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.]

**Experimental Service(s)** - services that are not recognized as efficacious as that term is defined in the edition of the *Institute 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 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 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 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** - an employee of the Enrolling Group who works, on average, at least 30 hours per week.

**Genetic Testing** - examination of blood or other tissue for chromosomal and DNA abnormalities and alterations, or other expressions of gene abnormalities that may indicate an increased risk for developing a specific disease or disorder.

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

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

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

- It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

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

**Initial Enrollment Period** - the initial period of time during which Eligible Persons may enroll themselves and their Dependents under the Policy.

**Injury** - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

**Inpatient Stay** - an uninterrupted confinement that follows formal admission to a Hospital, Skilled Nursing Facility or Related Institution.

**Intensive Outpatient Treatment** - a structured outpatient mental health or substance use disorder treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

**Medically Necessary** - health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance use disorder, condition, disease or its symptoms, that are all of the following as determined by us or our designee, within our sole discretion.

- In accordance with *Generally Accepted Standards of Medical Practice*.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance use disorder, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

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

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within our sole discretion.

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 on [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.

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

**Mental Health Services** - Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

**Mental Health/Substance Use Disorder Designee** - the organization or individual, designated by us, that provides or arranges Mental Health Services and Substance Use Disorder Services for which Benefits are available under the Policy.

**Mental Illness** - those mental health or psychiatric diagnostic categories that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded under the Policy.

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

**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; however, this does not include those providers who have agreed to discount their charges for Covered Health Services by way of their participation in the [Shared Savings Program]. 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 Services, but not all Covered Health 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 Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

**Network Benefits** - This is the description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to the *Schedule of Benefits* for details about how Network Benefits apply.

**Non-Network Benefits** - This is the description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to the *Schedule of Benefits* for details about how Non-Network Benefits apply.

*[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 Enrolling 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.]

**Out-of-Pocket Maximum** - The maximum amount of Copayments, deductibles, and Coinsurance you incur every year. Refer to the *Schedule of Benefits* for details about how the Out-of-Pocket Maximum applies.

**Partial Hospitalization/Day Treatment** - the provision of medically directed intensive or intermediate short term psychiatric treatment for a period of less than 24 hours but more than 4 hours in a day for a Covered Person in a Hospital, psychiatric day-care treatment center, or community mental health facility.

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

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

**Per Occurrence Deductible** - for Benefit plans that have a Per Occurrence Deductible, this is the amount of Eligible Expenses (stated as a set dollar amount) that you must incur for certain Covered Health Services prior to and in addition to any Annual Deductible before we will begin paying for Benefits for those Covered Health Services.

When a Benefit plan has a Per Occurrence Deductible, you are responsible for paying the lesser of the following:

- The applicable Per Occurrence Deductible.
- The Eligible Expense.

Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to payment of a Per Occurrence Deductible and for details about the specific Covered Health Services to which the Per Occurrence Deductible applies.

**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.

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

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

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

[<sup>1</sup>Applies to Off Exchange plans only]

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

- The *Group Policy*.
- This *Certificate*.
- The *Schedule of Benefits*.
- [<sup>1</sup>The Enrolling Group's application.]
- Riders.
- Amendments.
- Notices of Change.

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

**Policy Charge** - the sum of the Premiums for all Subscribers and Enrolled Dependents enrolled under the Policy.

**Pregnancy** - includes all of the following:

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

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

**Preventive Care Medications** - the medications that are obtained at a Network pharmacy and that are payable at 100% of Eligible Expenses (without application of any Copayment, Coinsurance, or any deductible) as required by applicable law under any of the following:

- Evidence-based items or services, inclusive of current recommendations for breast cancer, that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive*

*Services Task Force*. Note that recommendations of the *United States Preventive Services Task Force* regarding breast cancer screening, mammography and prevention issued in or around November 2009 are not considered to be current.

- 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*.

When Preventive Care Medications are received from a non-Network Pharmacy, Benefits will be available to at least 80% of Eligible Expenses.

You may determine whether a drug is a Preventive Care Medication through the internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

**Primary 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:

- No skilled services are identified.
- Skilled nursing resources are available in the facility.
- The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.
- 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.

[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.]

**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.

**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 *Department of Health and Mental Hygiene* to provide residential crisis services.

**Residential Treatment Facility** - a facility which provides a program of effective Mental Health Services or Substance Use Disorder Services treatment and which meets all of the following requirements:

- It is established and operated in accordance with applicable state law for residential treatment programs.

- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance Use Disorder Designee.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu:
  - 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 Services not described in this *Certificate*. Covered Health Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended in the Rider.

**Semi-private Room** - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

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

**[Shared Savings Program]** - the [Shared Savings Program] provides access to discounts from the provider's charges when services are rendered by those non-Network providers that participate in that program. We will use the [Shared Savings Program] to pay claims when doing so will lower Eligible Expenses. We do not credential the [Shared Savings Program] providers and the [Shared Savings Program] providers are not Network providers. Accordingly, in Benefit plans that have both Network and Non-Network levels of Benefits, Benefits for Covered Health Services provided by [Shared Savings Program] providers will be paid at the Non-Network Benefit level (except in situations when Benefits for Covered Health Services provided by non-Network providers are payable at Network Benefit levels, as in the case of Emergency Health Services). When we use the [Shared Savings Program] to pay a claim, patient responsibility is limited to Coinsurance calculated on the contracted rate paid to the provider, in addition to any required deductible.

*[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* does not include Mental Illness or substance use disorders, regardless of the cause or origin of the Mental Illness or substance use disorder.

**Skilled Nursing Facility** - an institution, or a distinct part of an institution, licensed by the *Department of Health and Hygiene*, which is:

- Primarily engaged in providing:
  - Skilled nursing care and related services, for residents who require medical or nursing care, or
  - Rehabilitation services for the rehabilitation of the Injured, disabled, or Sick persons; and
- Certified by the Medicare Program as a skilled nursing facility.

**Small Employer** - an employer that, during the preceding calendar year, employed an average of not more than:

- 50 employees if the preceding calendar year ended on or before January 1, 2016; and
- 100 employees if the preceding calendar year ended after January 1, 2016.

For the purpose of this definition:

- All persons treated as a single employer under § 414(b), (c), (m), 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
- 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.

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

**Specialty Prescription Drug Product** - Prescription drug products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. You may access a complete list of Specialty Prescription Drug Products through the Internet at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card.

**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 Enrolling Group.

**Substance Use Disorder Services** - Covered Health Services for the diagnosis and treatment of alcoholism and substance use disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

**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.

**Transitional Care** - Mental Health Services and Substance Use Disorder Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- Supervised living arrangements which are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements

may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

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

# **UnitedHealthcare Insurance Company**

[185 Asylum Street]

[Hartford, Connecticut 06103-3408]

[1-800-357-1371]

[<sup>1</sup>Variable for possible future product name change.][<sup>2</sup>Gold 7 - On and off the Exchange. Include only if metallic level needs to be included in Schedule issued to member.][<sup>3</sup>Include if AV needs to be included in Schedule issued to member]

# [<sup>1</sup>Choice Plus][<sup>2</sup>Gold 7][<sup>3</sup>Actuarial Value 78.04%]

## UnitedHealthcare Insurance Company Schedule of Benefits

### Accessing Benefits

You can choose to receive Network Benefits or Non-Network Benefits.

**Network Benefits** apply to Covered Health Services that are provided by a Network Physician or other Network provider. For facility services, these are Benefits for Covered Health Services that are provided at a Network facility. Emergency Health Services are always paid as Network Benefits.

**Non-Network Benefits** apply to Covered Health Services that are provided by a non-Network Physician or other non-Network provider, or Covered Health Services that are provided at a non-Network facility.

[Shared Saving name bracketed for possible future name change.]

Depending on the geographic area and the service you receive, you may have access through our [Shared Savings Program] to non-Network providers who have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from these providers, the Coinsurance will remain the same as it is when you receive Covered Health Services from non-Network providers who have not agreed to discount their charges; however, the total that you owe may be less when you receive Covered Health Services from [Shared Savings Program] providers than from other non-Network providers because the Eligible Expense may be a lesser amount.

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 [<sup>1</sup>UnitedHealthcare Choice Plus] 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 Enrolling Group, this *Schedule of Benefits* will control.

### Prior Authorization

We require prior authorization for certain Covered Health Services. Network providers are responsible for obtaining prior authorization before they provide these services to you.

We recommend that you confirm with us that all Covered Health Services have been prior authorized. Before receiving services from a Network provider, you may want to contact 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 fail to prior authorize as required. You can contact us by calling the telephone number for *Customer Care* on your ID card.

**When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for obtaining prior authorization before you receive these services. Note that your**

**obligation to obtain prior authorization is also applicable when a non-Network provider intends to admit you to a Network facility or refers you to other Network providers. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.**

**To obtain prior authorization, call the telephone number for *Customer Care* on your ID card.** This call starts the utilization review process.

When you choose to receive services from non-Network providers, we urge you to confirm with us that the services you plan to receive are Covered Health Services. That's because in some instances, certain procedures may not be Medically Necessary or may not otherwise meet the definition of a Covered Health Service, and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions.

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

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

## 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.

Utilization review is provided to determine whether the requested service is a Covered Health Service. 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 will be made within two (2) working days after receipt of information necessary to make the determination.

Utilization review determinations to authorize or certify an extended stay in a health care facility or to provide additional health care service will be made within one (1) working day after receipt of necessary information.

If within three (3) days after the receipt of the initial request, additional information is required to make a determination, your provider will be notified that additional information is required.

When prior authorization is required for inpatient or Residential Crisis Services for the treatment of Mental Health or substance use disorders, determinations on whether or not to authorize or certify such services will be made within 2 hours after receipt of necessary information.

Prior authorization is not required for Emergency Health 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 will take place by telephone on an expedited basis within 24 hours of the request for reconsideration.

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 Services and Substance Use Disorder 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 submitted by electronic transfer.

## Care Management

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

## Patient Centered Medical Homes

Benefits may 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.

## Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before we pay Benefits under the Policy), the prior authorization requirements do not apply to you. Since Medicare is the primary payer, we will pay as secondary payer as described in *Section 7: Coordination of Benefits*. You are not required to obtain authorization before receiving Covered Health Services.

## Benefits

<sup>1</sup> Applies when plan design calculates benefits and cost sharing provisions on a calendar basis.]

<sup>2</sup> Applies when plan design calculates benefits and cost sharing provisions on a policy year basis.]

Annual Deductibles are calculated on a [<sup>1</sup>calendar] [<sup>2</sup>Policy] year basis.

Out-of-Pocket Maximums are calculated on a [<sup>1</sup>calendar] [<sup>2</sup>Policy] year basis.

When Benefit limits apply, the limit stated refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

Benefit limits are calculated on a [<sup>1</sup>calendar] [<sup>2</sup>Policy] year basis unless otherwise specifically stated.

Payment Term And Description	Amounts
<b>Annual Deductible</b>	
<p>The amount of Eligible Expenses you must incur for Covered Health Services per year before you are eligible to receive Benefits.</p> <p>The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i> table.</p> <p><i>Always include for calendar year plans.</i></p> <p>[Any deductible amounts that were satisfied under a prior policy in the same calendar year will be applied to reduce the Annual Deductible amount that applies under this Policy. Prior policy includes both policies issued by us and policies issued by another carrier.]</p> <p><sup>1</sup><i>Roll-over provision applies only to groups changing from calendar to policy year.</i></p> <p>[<sup>1</sup>When the Enrolling Group changes from a calendar year to a Policy year plan, any amount you pay for medical expenses in the last three months of the previous calendar year that is applied to the previous Annual Deductible, will be rolled over and applied to the current Policy year Annual Deductible. This roll-over feature applies only to the first Policy year.]</p>	<p><i>Network</i></p> <p>For single coverage, the Annual Deductible is \$1,300 per Covered Person.</p> <p>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 \$2,600. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.</p> <p><i>Non-Network</i></p> <p>For single coverage, the Annual Deductible is \$2,000 per Covered Person.</p> <p>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</p>
<b>Out-of-Pocket Maximum</b>	

Payment Term And Description	Amounts
<p>The maximum you incur per year for the Annual Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year.</p> <p><i>Always include for calendar year plans.</i></p> <p>[Any out-of-pocket amounts that were satisfied under a prior policy in the same calendar year will be applied to reduce the Out-of-Pocket Maximum amount that applies under this Policy. Prior policy includes both policies issues by us and policies issued by another carrier.]</p> <p>The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following:</p> <ul style="list-style-type: none"> <li>• Any charges for non-Covered Health Services.</li> <li>• Charges that exceed Eligible Expenses.</li> </ul>	<p><i>Network</i></p> <p>For single coverage, the Out-of-Pocket Maximum is \$2,600 per Covered Person.</p> <p>If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is \$5,200.</p> <p><i>Non-Network</i></p> <p>For single coverage, the Out-of-Pocket Maximum is \$6,000 per Covered Person.</p> <p>If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is \$12,000.</p>
<b>Copayment</b>	
<p>Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service.</p> <p>Please note that for Covered Health Services, you are responsible for paying the lesser of:</p> <ul style="list-style-type: none"> <li>• The applicable Copayment.</li> <li>• The Eligible Expense.</li> </ul> <p>Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i> table.</p>	
<b>Coinsurance</b>	
<p>Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services.</p> <p>Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i> table.</p>	

As required under the *Patient Protection and Affordable Care Act (PPACA)* the Covered Person's responsibility for any applicable Coinsurance, Copayments and deductibles apply to the Out-of-Pocket Maximum. Refer to *Out-of-Pocket Maximum* above for details about how the Out-of-Pocket Maximum applies.

*When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.*

<b>Covered Health Service</b>	<b>Benefit</b> <i>(The Amount We Pay, based on Eligible Expenses)</i>	<b>Apply to the Out-of-Pocket Maximum?</b>	<b>Must You Meet Annual Deductible?</b>
<b>1. Ambulance Services</b>			
	<i>Network</i> 100%  <i>Non-Network</i> 80%	No  Yes	Yes  Yes
<b>2. Blood and Blood Products</b>			
	<i>Network</i> 100%  <i>Non-Network</i> 80%	No  Yes	Yes  Yes
<b>3. Case Management Services</b>			
	<i>Network</i> Depending upon where the Covered Health Service is provided Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .  <i>Non-Network</i> Depending upon where the Covered Health Service is provided Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .		
<b>4. Chiropractic Services</b>			
Limited to 20 visits per condition per year	<i>Network</i> 100%  <i>Non-Network</i> 80%	No  Yes	Yes  Yes

<i>When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.</i>			
<b>Covered Health Service</b>	<b>Benefit</b> <i>(The Amount We Pay, based on Eligible Expenses)</i>	<b>Apply to the Out-of-Pocket Maximum?</b>	<b>Must You Meet Annual Deductible?</b>
<b>5. Controlled Clinical Trials</b>			
<p>Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this <i>Schedule of Benefits</i>.</p> <p>Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider should agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Non-Network Benefits will continue to be available if the non-Network provider does not agree to accept the Network level of reimbursement.)</p>	<p><i>Network</i> Depending upon where the Covered Health Service is provided Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p> <p><i>Non-Network</i> Depending upon where the Covered Health Service is provided Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p>		
<b>6. Dental Services - Hospital and Ambulatory Facility Charges Related to Dental Care</b>			
	<p><i>Network</i> 100%</p> <p><i>Non-Network</i> 80%</p>	<p>No</p> <p>Yes</p>	<p>Yes</p> <p>Yes</p>
<b>7. Detoxification Services</b>			
	<p><i>Network</i> 100%</p> <p><i>Non-Network</i> 80%</p>	<p>No</p> <p>Yes</p>	<p>Yes</p> <p>Yes</p>
<b>8. Diabetes Treatment, Equipment</b>			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<b>and Supplies</b>			
<p><i>Network</i></p> <p>Depending upon where the Covered Health Service is provided, Benefits for diabetes treatment will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p> <p>Depending upon where the Covered Health Service is provided, Benefits for diabetes equipment and supplies will be the same as those stated under <i>Durable Medical Equipment</i> and <i>Prescription Drug Products</i>.</p> <p><i>Non-Network</i></p> <p>Depending upon where the Covered Health Service is provided, Benefits for diabetes treatment will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p> <p>Depending upon where the Covered Health Service is provided, Benefits for diabetes equipment and supplies will be the same as those stated under <i>Durable Medical Equipment</i> and <i>Prescription Drug Products</i>.</p>			
<b>9. Durable Medical Equipment</b>			
<p>To receive Network Benefits, you must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.</p>	<p><i>Network</i></p> <p>100%</p> <p><i>Non-Network</i></p> <p>80%</p>	<p>No</p> <p>Yes</p>	<p>Yes</p> <p>Yes</p>
<b>10. Emergency Health Services</b>			
<p><b>Note:</b> If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify us within one business day or on the same day of admission if reasonably possible. We may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the non-Network Hospital after</p>	<p><i>Network</i></p> <p>100% after you pay a Copayment of \$250 per visit</p>	<p>Yes</p>	<p>Yes</p>

*When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.*

<b>Covered Health Service</b>	<b>Benefit</b> <i>(The Amount We Pay, based on Eligible Expenses)</i>	<b>Apply to the Out-of-Pocket Maximum?</b>	<b>Must You Meet Annual Deductible?</b>
<p>the date we decide a transfer is medically appropriate, Network Benefits will not be provided. Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service.</p>	<p><i>Non-Network</i> Same as Network</p>	<p>Same as Network</p>	<p>Same as Network</p>
<b>11. Family Planning Services</b>			
	<p><i>Network</i> 100% <i>See Prescription Drug Products for cost sharing for contraceptive Prescription Drug Products</i></p> <p><i>Non-Network</i> 80% <i>See Prescription Drug Products for cost sharing for contraceptive Prescription Drug Products</i></p>	<p>No</p> <p>Yes</p>	<p>Yes</p> <p>Yes</p>
<b>12. Habilitative Services</b>			
<p><i>Per MD Bulletin 13-01, Habilitative Service for covered person age 19 and older may be provided to the same extent as rehabilitation services - outpatient.</i></p> <p>For Covered Persons age 19 or older, limited to:</p> <ul style="list-style-type: none"> <li>• 30 physical therapy visits per condition per year.</li> <li>• 30 speech therapy visits per</li> </ul>	<p><i>Network</i> 100%</p>	<p>No</p>	<p>Yes</p>

*When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.*

<b>Covered Health Service</b>	<b>Benefit</b> <i>(The Amount We Pay, based on Eligible Expenses)</i>	<b>Apply to the Out-of-Pocket Maximum?</b>	<b>Must You Meet Annual Deductible?</b>
<p>condition per year.</p> <ul style="list-style-type: none"> <li>30 occupational therapy visits per condition per year.</li> </ul>	<p><i>Non-Network</i> 80%</p>	<p>Yes</p>	<p>Yes</p>
<b>13. Hearing Aids</b>			
<p>Limited to one hearing aid per hearing impaired ear every 36 months.</p>	<p><i>Network</i> 100%</p> <p><i>Non-Network</i> 80%</p>	<p>No</p> <p>Yes</p>	<p>Yes</p> <p>Yes</p>
<b>14. Home Health Care Services</b>			
	<p><i>Network</i> 100%</p> <p><i>Non-Network</i> 80%</p>	<p>No</p> <p>Yes</p>	<p>Yes</p> <p>Yes</p>
<b>15. Hospice Care Services</b>			
	<p><i>Network</i> 100%</p> <p><i>Non-Network</i> 80%</p>	<p>No</p> <p>Yes</p>	<p>Yes</p> <p>Yes</p>
<b>16. Infertility Services</b>			
	<p><i>Network</i> 100%</p>	<p>No</p>	<p>Yes</p>

*When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.*

<b>Covered Health Service</b>	<b>Benefit</b> <i>(The Amount We Pay, based on Eligible Expenses)</i>	<b>Apply to the Out-of-Pocket Maximum?</b>	<b>Must You Meet Annual Deductible?</b>
	<i>Non-Network</i> 80%	Yes	Yes
<b>17. Inpatient Hospital Services</b>			
	<i>Network</i> 100%	No	Yes
	<i>Non-Network</i> 80%	Yes	Yes
<b>18. Medical Foods</b>			
	<i>Network</i> 100%	No	Yes
	<i>Non-Network</i> 80%	Yes	Yes
<b>19. Medical Office Services</b>			
	<i>Network</i> 100%	No	Yes
	<i>Non-Network</i> 80%	Yes	Yes
<b>20. Mental Health and Substance Use Disorder Services - Inpatient</b>			
	<i>Network</i> 100%	No	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

Covered Health Service	<b>Benefit</b> <i>(The Amount We Pay, based on Eligible Expenses)</i>	<b>Apply to the Out-of-Pocket Maximum?</b>	<b>Must You Meet Annual Deductible?</b>
	<i>Non-Network</i> 80%	Yes	Yes
<b>21. Mental Health and Substance Use Disorder Services - Outpatient</b>			
	<i>Network</i> 100%	No	Yes
	<i>Non-Network</i> 80%	Yes	Yes
<b>22. Nutritional Services and Medical Nutrition Therapy</b>			
	<i>Network</i> 100%	No	Yes
	<i>Non-Network</i> 80%	Yes	Yes
<b>23. Outpatient Hospital Services</b>			
	<i>Network</i> 100%	No	Yes
	<i>Non-Network</i> 80%	Yes	Yes
<b>24. Outpatient Laboratory and Diagnostic Services</b>			
	<i>Network</i> 100%	No	Yes
	<i>Non-Network</i> 80%	Yes	Yes



*When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.*

<b>Covered Health Service</b>	<b>Benefit</b> <i>(The Amount We Pay, based on Eligible Expenses)</i>	<b>Apply to the Out-of-Pocket Maximum?</b>	<b>Must You Meet Annual Deductible?</b>
<p>price of the Prescription Drug Product.</p> <p>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 <i>Medicare Part D</i> plan sponsors by the <i>Centers for Medicare and Medicaid</i>; 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.</p>	<p>Copayment of \$10 per prescription order or refill</p> <p><i>Tier 1-Specialty</i></p> <p>100% after you pay a Copayment of \$10 per prescription order or refill</p> <p><i>Tier 2</i></p> <p>100% after you pay a Copayment of \$40 per prescription order or refill</p> <p><i>Tier 2-Specialty</i></p> <p>100% after you pay a Copayment of \$100 per prescription order or refill</p> <p><i>Tier 3</i></p> <p>100% after you pay a Copayment of \$75 per prescription order or refill</p> <p><i>Tier 3-Specialty</i></p> <p>100% after you pay a Copayment of \$300 per prescription order or refill</p> <p><i>Non-Network</i></p> <p><i>Tier 1</i></p> <p>100% after you pay a Copayment of \$10 per prescription order or refill</p> <p><i>Tier 1-Specialty</i></p> <p>100% after you pay a</p>	<p>Yes</p>	<p>Yes</p>

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<p>Copayment of \$10 per prescription order or refill</p> <p><i>Tier 2</i></p> <p>100% after you pay a Copayment of \$40 per prescription order or refill</p> <p><i>Tier 2-Specialty</i></p> <p>100% after you pay a Copayment of \$100 per prescription order or refill</p> <p><i>Tier 3</i></p> <p>100% after you pay a Copayment of \$75 per prescription order or refill</p> <p><i>Tier 3-Specialty</i></p> <p>100% after you pay a Copayment of \$300 per prescription order or refill</p>		
<b>28. Preventive Care Services</b>			
	<p><i>Network</i></p> <p>100%</p> <p><i>Non-Network</i></p> <p>80%</p>	<p>No</p> <p>Yes</p>	<p>No</p> <p>Yes</p>
<b>29. Reconstructive Breast Surgery and Breast Prosthesis</b>			
	<p><i>Network</i></p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered</p>		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	Health Service category in this <i>Schedule of Benefits</i>  <i>Non-Network</i>  Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>		
<b>30. Skilled Nursing Facility Services</b>			
Limited to 100 days per year	<i>Network</i>  100%  <i>Non-Network</i>  80%	No   Yes	Yes   Yes
<b>31. Surgical Morbid Obesity Treatment</b>			
	<i>Network</i>  Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .  <i>Non-Network</i>  Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .		
<b>32. Transplantation Services</b>			
	<i>Network</i>  100%  <i>Non-Network</i>  80%	No   Yes	Yes   Yes
<b>33. Urgent Care Center Services</b>			
	<i>Network</i>  100%	No	Yes

*When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.*

<b>Covered Health Service</b>	<b>Benefit</b> <i>(The Amount We Pay, based on Eligible Expenses)</i>	<b>Apply to the Out-of-Pocket Maximum?</b>	<b>Must You Meet Annual Deductible?</b>
	Non-Network 80%	Yes	Yes

## Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount we will pay for Eligible Expenses except that this provision does not apply to Benefits received due to services provided by on-call Physicians, Hospital-based Physicians, or ambulance service providers as defined under Maryland law, who have accepted an assignment of Benefits. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Certificate*.

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

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as a result of an Emergency or as otherwise arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated.

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

- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on:
  - Negotiated rates agreed to by the non-Network provider and either us or one of our vendors, affiliates or subcontractors, at our discretion.
  - If rates have not been negotiated, then one of the following amounts:
    - ◆ Eligible Expenses are determined based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market.
    - ◆ When a rate is not published by *CMS* for the service, we use an available gap methodology to determine a rate for the service as follows:
      - For services other than pharmaceutical products, we use a gap methodology that uses a relative value scale, which is usually based on the difficulty, time, work, risk and resources of the service. The relative value scale currently used is created by *Ingenix, Inc.* If the *Ingenix, Inc.* relative value scale becomes no longer available, a comparable scale will be used. We and *Ingenix, Inc.* are related companies through common ownership by *UnitedHealth Group*.
      - For pharmaceutical products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters*

(published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

- ◆ When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge, except that certain Eligible Expenses for Mental Health Services and Substance Use Disorder Services are based on 80% of the billed charge.

However, Eligible Expenses for a Covered Health Service received from a non-Network provider will never be less than Eligible Expenses for that same Covered Health Service if that Covered Health Service had been received from a Network provider in the same geographic area.

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

The following provision applies to on-call Physicians or Hospital-based Physicians who are:

- Non-Network providers;
- Have obtained an assignment of Benefits; and
- Who have notified us in a manner specified by the Insurance Commissioner that they have obtained and accepted an assignment of Benefits.

Payment for a claim submitted by an on-call Physician for a Covered Health Service rendered to a Covered Person in a Hospital will be no less than the greater of:

- 140% of the average rate we paid for the 12-month period that ends on January 1 of the previous calendar year in the same geographic area, as defined by the *Centers for Medicare and Medicaid Services*, for the same Covered Health Service, to similarly licensed Network providers; or
- The average rate we paid for the 12-month period that ended on January 1, 2010, in the same geographic area, as defined by the *Centers for Medicare and Medicaid Services*, for the same Covered Health Service to a similarly licensed non-Network provider, inflated by the change in the *Medicare Economic Index* from 2010 to the current year.

Payment for a claim submitted by a Hospital-based Physician for a Covered Health Service rendered to a Covered Person will be no less than the greater of:

- 140% of the average rate we paid for the 12-month period that ends on January 1 of the previous calendar year in the same geographic area, as defined by the *Centers for Medicare and Medicaid Services*, for the same Covered Health Service, to similarly licensed providers, who are Network Hospital-based Physicians; or

Our final Eligible Expense for the same Covered Health Service for the 12-month period that ended on January 1, 2010, inflated by the change in the *Medicare Economic Index* to the current year, to the Hospital-based Physician billing under the same federal tax identification number the Hospital-based Physician used in calendar year 2009.

## Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select 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 *Customer Care*. A directory of providers is available online at [www.myuhc.com] or by calling *Customer Care* at the telephone number on your ID card to request a copy.

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 Network Benefits.

If you are currently undergoing a course of treatment utilizing a non-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 determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health 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 assistance.

## **Designated Facilities and Other Providers**

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses at our discretion.

In both cases, Network Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Network Benefits will not be paid. Non-Network Benefits may be available if the special needs services you receive are Covered Health Services for which Benefits are provided under the Policy.

## **Health Services from Non-Network Providers Paid as Network Benefits**

If you are diagnosed with a condition or disease that requires specialized health care services or medical care and such specialized service or care is either not available from a Network provider or access to such a Network provider would require unreasonable delay or travel, you may be eligible for Network Benefits when Covered Health Services are received from non-Network providers.

In this situation, you may request a referral to a non-Network provider 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, we will work with you and your Network Physician to coordinate care through a non-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 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 fail to use the selected Network Physician, Covered Health Services will be paid as Non-Network Benefits.

Mandatory EHB Rider which must be attached to Policies issued to any non-grandfathered plan in the small group market.

## Pediatric Dental Services Rider

### UnitedHealthcare Insurance Company

[This Rider may be used with the following Plan Designs. Include when metal level is required to be included in the member Rider.]

**[Bronze 1] [Gold [1][3][7][10]] [Platinum [1][3]] [Silver [2][3][4][8]]**

[<sup>1</sup>Insert the termination date as selected by the plan.]

This Rider to the Policy is issued to the Enrolling Group and provides Benefits for Covered Dental Services, as described below, for Covered Persons under the age of 19. Benefits under this Rider terminate on the [<sup>1</sup>date] [<sup>1</sup>last day of the month] [<sup>1</sup>last day of the [Policy] [calendar] year] the Covered Person reaches the age of 19.

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 5: Defined Terms for Pediatric Dental Services*.

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare 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*.

---

[Signature of authorized company officer]

[Title of authorized company officer]

## Section 1: Accessing Pediatric Dental Services

### Network and Non-Network Benefits

**Network Benefits** - these Benefits apply when you choose to obtain Covered Dental Services from a Network Dental Provider. You generally are required to pay less to the provider than you would pay for services from a non-Network 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 in excess of the contracted fee.

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

You must always verify the participation status of a provider prior to seeking services. From time to time, the participation status of a provider may change. You can verify the participation status by calling us and/or the provider. If necessary, we can provide assistance in referring you to Network Dental Provider.

We will make available to you a *Directory of Network Dental Providers*. You can also call *Customer Service* to determine which providers participate in the Network. The telephone number for *Customer Service* is on your ID card.

**Non-Network Benefits** - these Benefits apply when you decide to obtain Covered Dental Services from non-Network Dental Providers. You generally are required to pay more to the provider than for Network Benefits. Non-Network Benefits are determined based on the Usual and Customary fee for similarly situated Network Dental Providers for each Covered Dental Service. The actual charge made by a non-Network Dental Provider for a Covered Dental Service may exceed the Usual and Customary fee. As a result, you may be required to pay a non-Network Dental Provider an amount for a Covered Dental Service in excess of the Usual and Customary fee. In addition, when you obtain Covered Dental Services from non-Network Dental Providers, you must file a claim with us to be reimbursed for Eligible Dental Expenses.

### Dental Services from Non-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 non-Network Dental Providers.

In this situation, you may request a referral to a non-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, we will work with you and your Network Dental Provider to coordinate care through a non-Network Dental Provider. When coordinated, such service received from a non-Network Dental Provider will be treated as Network Benefits, including any applicable Copayment, Coinsurance and deductible requirements.

### 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.

### Pre-Treatment Estimate

If the charge for a Dental Service is expected to exceed \$500 or if a dental exam reveals the need for fixed bridgework, you may notify us of such treatment before treatment begins and receive a pre-treatment estimate. If you desire a pre-treatment estimate, you or your Dental Provider should send a notice to us 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 assigned 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.

### **Pre-Authorization**

Pre-authorization is required for orthodontic services. Speak to your Dental Provider about obtaining a pre-authorization before Dental Services are rendered.

## **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 assigned a Benefit based on the least costly procedure.
- D. Not excluded as described in *Section 3: Pediatric Dental Services exclusions* of this Rider.

### **Network Benefits:**

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

### **Non-Network Benefits:**

Benefits for Eligible Dental Expenses from non-Network providers are determined as a percentage of the Usual and Customary fees. You must pay the amount by which the non-Network provider's billed charge exceeds the Eligible Dental Expense. However, Eligible Dental Expenses for Covered Dental Services received from a non-Network provider will never be less than Eligible Dental Expense for that same Covered Dental Service if that Covered Dental Service had been received from a Network provider in the same geographic area.

### **Annual Deductible**

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

**Out-of-Pocket Maximum** - any amount you incur in Coinsurance for pediatric Dental Services under this Rider applies to the Out-of-Pocket Maximum 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:**

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**

**Note: Use of calendar year or Policy year must mirror those in the medical SBN.**

When Benefit limits apply, the limit stated refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

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

**Benefit Description**

Benefit Description and Limitations	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
<i>Diagnostic Services</i>		
<i>Intraoral Bitewing Radiographs (Bitewing X-ray)</i>	100%	100%
<i>Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays)</i>	100%	100%
<i>Periodic Oral Evaluation (Check up Exam)</i> 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.	100%	100%
<i>Preventive Services</i>		
<i>Dental Prophylaxis (Cleanings)</i> Limited to 2 times per 12 months.	100%	100%

<b>Benefit Description and Limitations</b>	<b>Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.</b>	<b>Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.</b>
<p><i>Fluoride Treatments</i></p> <p>Limited to 4 times per 12 months for Covered Persons age 3 years and older. Limited to 8 times per 12 months for Covered Persons age 0-2 years. Treatment should be done in conjunction with dental prophylaxis.</p>	100%	100%
<p><i>Sealants (Protective Coating)</i></p> <p>For teeth 2-5, 12-15, 18-21, 28-31: Limited to one per lifetime per Covered Person per tooth. Benefits are provided only for the occlusal surfaces of posterior permanent teeth without restorations or decay.</p>	100%	100%
<i>Space Maintainers</i>		
<p><i>Space Maintainers (Spacers)</i></p> <p>Limited to Covered Persons under the age of 19.</p> <p>Limited to 1 per 24 months per quadrant: <i>Space Maintainer-Fixed-Unilateral</i> and <i>Space Maintainer-Removable-Unilateral</i></p> <p>Limited to 1 per 24 months per arch: <i>Space Maintainer-Fixed-Bilateral</i> and <i>Space Maintainer-Removable-Bilateral</i>.</p> <p>Benefit includes all adjustments within 6 months of installation.</p>	80%	80%
<i>Minor Restorative Services, Endodontics, Periodontics and Oral Surgery</i>		
<p><i>Amalgam Restorations (Silver Fillings)</i></p> <p>Multiple restorations on one surface will be treated as a single filling.</p>	80%	80%
<i>Composite Resin Restorations</i>	80%	80%

<b>Benefit Description and Limitations</b>	<b>Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.</b>	<b>Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.</b>
<p><i>(Tooth Colored Fillings)</i></p> <p><i>Resin-Based Composite - 1 Surface Posterior:</i> Limited to one per 36 months per Covered Person per tooth, per surface</p> <p><i>Resin-Based Composite- 2 Surfaces, Posterior:</i> Limited to one per 36 months per Covered Person per tooth, per surface.</p> <p><i>Resin-Based Composite - 3 Surfaces, Posterior:</i> Limited to one per 36 months per Covered Person per tooth, per surface.</p> <p><i>Resin-Based Composite - 4 or more Surfaces, Posterior:</i> Limited to one per 36 months per Covered Person per tooth, per surface.</p>		
<p><i>Endodontics (Root Canal Therapy)</i></p> <p>Limited one per lifetime per Covered Person per tooth</p> <p><i>Retreatment of Previous Root Canal Therapy - Anterior, Retreatment of Previous Root Canal Therapy - Bicuspid; and Retreatment of Previous Root Canal Therapy - Molar</i> is not allowed within 24 months of initial treatment by the same Dental Provider</p>	80%	80%
<p><i>Periodontal Surgery (Gum Surgery)</i></p> <p>Limited 1 quadrant or site per 24 months per surgical area.</p>	80%	80%
<p><i>Scaling and Root Planing (Deep Cleanings)</i></p> <p>Limited to 1 time per quadrant per 24 months.</p>	80%	80%
<p><i>Periodontal Maintenance (Gum</i></p>	80%	80%

<b>Benefit Description and Limitations</b>	<b>Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.</b>	<b>Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.</b>
<p><i>Maintenance)</i> Limited to 2 times per 12 month period following active and adjunctive periodontal therapy, within the prior 24 months, exclusive of gross debridement.</p>		
<p><i>Simple Extractions (Simple tooth removal)</i></p>	80%	80%
<p><i>Oral Surgery, including Surgical Extraction</i></p>	80%	80%
<i>Adjunctive Services</i>		
<p><i>General Services (including Emergency Treatment)</i> Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary.</p>	80%	80%
<p><i>Major Restorative Services</i> Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement, except that the following are limited to 1 time per 36 months from initial or supplemental replacement: <i>Prefabricated Resin Crowns, Prefabricated Steel Crown with Resin Window, and Prefabricated Esthetic Coated Stainless Steel Crown - Primary Tooth.</i></p>		
<p><i>Inlays/Onlays/Crowns (Partial to Full Crowns)</i> Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth. <i>Except that the following crowns are limited to one per 36 months:</i></p> <ul style="list-style-type: none"> <li>• Prefabricated Resin Crown</li> <li>• Prefabricated Steel crown with Resin Window:</li> <li>• Prefabricated Esthetic Coated Stainless Steel</li> </ul>	50%	50%

<b>Benefit Description and Limitations</b>	<b>Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.</b>	<b>Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.</b>
Crown - Primary Tooth		
<p><i>Fixed Prosthetics (Bridges)</i></p> <p>Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.</p>	50%	50%
<p><i>Removable Prosthetics (Full or partial dentures)</i></p> <p>Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.</p>	50%	50%
<p><i>Relining and Rebasing Dentures</i></p> <p>Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.</p>	50%	50%
<p><i>Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges, or Crowns</i></p> <p><i>Except as described below:</i></p> <p>Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6 months.</p> <p><i>The following are limited to repairs and adjustment performed more than 6 months after initial insertion:</i> Adjust Complete Denture - Maxillary; Adjust Complete Denture-Mandibular; Adjust Partial Denture - Maxillary; Adjust Partial Denture-Mandibular.</p> <p><i>Limits do not apply to the following:</i></p> <p>Repair Broken Complete Dental Base Per Arch (01, 02, LA, UA); Replace Missing or Broken Teeth - Complete Denture (each tooth) (Teeth 1-</p>	50%	50%

<b>Benefit Description and Limitations</b>	<b>Network Benefits</b> Benefits are shown as a percentage of Eligible Dental Expenses.	<b>Non-Network Benefits</b> Benefits are shown as a percentage of Eligible Dental Expenses.
31; Repair Resin Denture Base per Arch (01, 02, LA, UA); Repair Cast Framework per Arch (01, 02, LA, UA); Repair or Replace Broken Clasp; Replace Broken Tooth - Per Tooth (Teeth 1-32); Add Tooth to Existing Partial Denture (Teeth 1-32); Add Clasp to Existing Partial Dental Denture.		
<b>MEDICALLY NECESSARY ORTHODONTICS</b>		
<p>Benefits for comprehensive orthodontic treatment are approved by us, only for Covered Persons with severe dysfunctional, handicapping malocclusion.</p> <p>All orthodontic treatment must be prior authorized.</p> <p><i>[<sup>1</sup>Insert appropriate payment schedule.]</i></p> <p>Benefits will be paid [<sup>1</sup>in equal [quarterly] [monthly] installments] [on a schedule determined by the Enrolling Group] 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.</p>		
<p><i>Orthodontic Services</i></p> <p>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.</p>	50%	50%

### Section 3: Pediatric Dental Exclusions

Except as may be specifically provided in this Rider under *Section 2: Benefits for Covered Dental Services*, Benefits are not provided under this Rider for the following:

1. Any Dental Service or Procedure not listed as a Covered Dental Service in this Rider in *Section 2: Benefits for Covered Dental Services*.
2. Dental Services that are not Necessary.
3. Hospitalization or other facility charges.
4. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
5. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, Injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.

6. Any Dental Procedure not directly associated with dental disease. This exclusion does not apply to preventive, diagnostic or orthodontic Dental Services.
7. Any Dental Procedure not performed in a dental setting.
8. Procedures that are considered to be Experimental Services. This includes pharmacological regimens not accepted by the *American Dental Association (ADA) Council on Dental Therapeutics*. The fact that an Experimental Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental in the treatment of that particular condition.
9. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
10. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
11. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision. This exclusion does not apply to the following when such Benefits are not provided under your medical coverage: Radical Excision - Lesion Diameter up to 1.25 cm; Excision of Malignant Tumor- Lesion Diameter up to 1.25 cm; Removal of Odontogenic Cyst or Tumor- Lesion Diameter up to 1.25 cm; Removal of Odontogenic Cyst or Tumor- Lesion Diameter greater than 1.25 cm; Removal of Non-odontogenic Cyst or Tumor- Lesion Diameter up to 1.25 cm; and Removal of Non-odontogenic Cyst or Tumor- Lesion Diameter greater than 1.25 cm..
12. Replacement of complete dentures, fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
13. Upper and lower jaw bone surgery. Orthognathic surgery and jaw alignment. This exclusion does not apply to Benefits provided for services related to temporomandibular joint disorder.
14. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
15. Dental Services otherwise covered under the Policy, but rendered after the date individual coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy terminates. This exclusion does not apply to Benefits provided as described above under *Benefits after Coverage Termination for Dental Services*.
16. Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child.
17. Foreign Services are not covered unless required as an Emergency.
18. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
19. Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service.
20. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
21. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
22. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan.

23. 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 4: Claims for Pediatric Dental Services

When obtaining Dental Services from a non-Network provider, you will be required to pay all billed charges directly to your Dental Provider. You may then seek reimbursement from us. Information about claim timelines and responsibilities in the *Certificate* in *Section 5: How to File a Claim* apply to Covered Dental Services provided under this Rider, except that when you submit your claim, you must provide us with all of the information identified below.

### Reimbursement for Dental Services

You are responsible for sending a request for reimbursement to our office.

**Claim Forms.** It is not necessary to include a claim form with the proof of loss. However, the proof must include all of the following information:

- Covered Person's name and address.
- Covered Person's identification number.
- The name and address of the provider of the service(s).
- A diagnosis from the Dental Provider including a complete dental chart showing extractions, fillings or other dental services rendered before the charge was incurred for the claim.
- Radiographs, lab or hospital reports.
- Casts, molds or study models.
- Itemized bill which includes the *CPT* or *ADA* codes or description of each charge.
- The date the dental disease began.
- A statement indicating that you are or you are not enrolled for coverage under any other health or dental insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

If you would like to use a claim form, call us at the telephone number stated on your ID Card and a claim form will be sent to you. If you do not receive the claim form within 15 calendar days of your request, send in the proof of loss with the information stated above.

## Section 5: Defined Terms for Pediatric Dental Services

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

**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 render Dental Services, perform dental surgery or administer 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 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*.

**Eligible Dental Expenses** - Eligible Dental Expenses for Covered Dental Services, incurred while the Policy is in effect, are determined as stated below:

- For Network Benefits, when Covered Dental Services are received from Network Dental Providers, Eligible Dental Expenses are our contracted fee(s) for Covered Dental Services with that provider.
- For Non-Network Benefits, when Covered Dental Services are received from Non-Network Dental Providers, Eligible Dental Expenses are the Usual and Customary fees, as defined below.

Eligible Dental Expenses for a Covered Dental Services received from a Non-Network Dental Provider will never be less than Eligible Dental Expenses for that same Covered Dental Service if that Covered Dental Service had been received from a Network Dental Provider in the same geographic area.

**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.
- Rendered 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.

**Usual and Customary** - Usual and Customary fees are calculated by us based on available data resources of competitive fees in that geographic area.

Usual and Customary fees must not exceed the fees that the provider would charge any similarly situated payor for the same services.

Usual and Customary fees are determined solely in accordance with our reimbursement policy guidelines. Our reimbursement policy guidelines are developed by us, in our discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology* (publication of the *American Dental Association*).
- As reported by generally recognized professionals or publications.
- As utilized for Medicare.
- As determined by medical or dental staff and outside medical or dental consultants.
- Pursuant to other appropriate source or determination that we accept.

Mandatory EHB Rider which must be attached to Policies issued to any non-grandfathered plan in the small group market.

# Pediatric Vision Care Services Rider

## UnitedHealthcare Insurance Company

[This Rider may be used with the following Plan Design. Include when metal level is required to be included in the member Rider.]

### [Gold 7]

[<sup>1</sup>Insert the termination date.]

This Rider to the Policy is issued to the Enrolling Group and provides Benefits for Vision Care Services, as described below, for Covered Persons under the age of 19. Benefits under this Rider terminate on the [<sup>1</sup>date] [<sup>1</sup>last day of the month] [<sup>1</sup>last day of the [Policy] [calendar] year] the Covered Person reaches the age of 19.

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 UnitedHealthcare 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*.

---

[Signature of authorized company officer]

[Title of authorized company officer]

## Section 1: Benefits for Pediatric Vision Care Services

*Include either "Network" or "Spectera Eyecare Networks" variables consistently to reflect applicable network of providers.*

Benefits are available for pediatric Vision Care Services from a [Spectera Eyecare Networks] [Network] or non-Network Vision Care Provider. To find a [Spectera Eyecare Networks] [Network] Vision Care Provider, you may call the provider locator service at [1-800-839-3242]. You may also access a listing of [Spectera Eyecare Networks] [Network] Vision Care Providers on the Internet at [www.myuhcvision.com or www.myspectera.com].

When you obtain Vision Care Services from a non-Network Vision Care Provider, you will be required to pay all billed charges at the time of service. You may then seek reimbursement from us as described in the *Certificate* in *Section 5: How to File a Claim* and in this Rider under *Section 3: Claims for Vision Care Services*. Reimbursement will be limited to the amounts stated below.

### Network 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.

### Non-Network Benefits:

Benefits for Vision Care Services from non-Network providers are determined as a percentage of the provider's billed charge. However, fees from a non-Network provider will never be less than the negotiated contract fee for that same Vision Care Service if that Vision Care Service had been received from a Network provider in the same geographic area.

**Out-of-Pocket Maximum** - any amount you incur in Coinsurance for Vision Care Services under this Rider applies to the Out-of-Pocket Maximum stated in the *Schedule of Benefits*.

### Annual Deductible

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

## Benefit Description

### Benefits

**Note: Use of calendar year or Policy year must mirror those in the medical SBN.**

When Benefit limits apply, the limit stated refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

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

### Frequency of Service Limits

Benefits are provided for the Vision Care Services described below, subject to *Frequency of Service* limits and Coinsurance stated under each Vision Care Service in the *Schedule of Benefits* below.

### Routine Vision Examination

A routine vision examination of the condition of the eyes and principal vision functions according to the standards of care in the jurisdiction in which you reside, including:

- A case history that includes chief complaint and/or reason for examination, patient medical/eye history, and current medications.
- Recording of monocular and binocular visual acuity, far and near, with and without present correction (for example, 20/20 and 20/40).

- Cover test at 20 feet and 16 inches (checks eye alignment).
- Ocular motility including versions (how well eyes track) near point convergence (how well eyes move together for near vision tasks, such as reading), and depth perception.
- Pupil responses (neurological integrity).
- External exam.
- Retinoscopy (when applicable) – objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.
- Phorometry/Binocular testing – far and near: how well eyes work as a team.
- Tests of accommodation and/or near point refraction: how well you see at near point (for example, reading).
- Tonometry, when indicated: test pressure in eye (glaucoma check).
- Ophthalmoscopic examination of the internal eye.
- Confrontation visual fields.
- Biomicroscopy.
- Color vision testing.
- Diagnosis/prognosis.
- Specific recommendations.

Post examination procedures will be performed only when materials are required.

Routine vision examinations will include dilation when professionally indicated.

Or, in lieu of a complete exam, Retinoscopy (when applicable) - objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.

## **Eyeglass Lenses**

Lenses that are mounted in eyeglass frames and worn on the face to correct visual acuity limitations.

You are eligible to select only one of either eyeglasses (*Eyeglass Lenses* and/or *Eyeglass Frames*) or *Contact Lenses*. If you select more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.

### **Optional Lens Extras**

Eyeglass Lenses. The following Optional Lens Extras are covered in full:

- Standard scratch-resistant coating.
- Polycarbonate lenses.

## **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 select only one of either eyeglasses (*Eyeglass Lenses* and/or *Eyeglass Frames*) or *Contact Lenses*. If you select more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.

## Contact Lenses

Lenses worn on the surface of the eye to correct visual acuity limitations.

Benefits include the fitting/evaluation fees and contacts.

You are eligible to select only one of either eyeglasses (*Eyeglass Lenses* and/or *Eyeglass Frames*) or *Contact Lenses*. If you select more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.

## Necessary Contact Lenses

Benefits are available when a Vision Care Provider has determined a need for and has prescribed the contact lens. Such determination will be made by the Vision Care Provider and not by us.

Contact lenses are necessary if you have any of the following:

- Keratoconus.
- Anisometropia.
- Irregular corneal/astigmatism.
- Aphakia.
- Facial deformity.
- Corneal deformity.

## Benefits after Coverage Termination for Vision Care Services

If a Covered Person has ordered prescription eyewear or contact lenses that are a covered expense before the date the Covered Person ceases to be insured under the Policy, we will continue to pay Benefits for those prescription eyewear or contact lenses after the date coverage terminates.

## Schedule of Benefits

Vision Care Service	Frequency of Service	Network Benefit	Non-Network Benefit
<i>Routine Vision Examination or Refraction only in lieu of a complete exam.</i>	Once per year.	100% Not subject to payment of the Annual Deductible.	80% of the billed charge

Vision Care Service	Frequency of Service	Network Benefit	Non-Network Benefit
---------------------	----------------------	-----------------	---------------------

<i>Low Vision Services</i> <i>(Comprehensive Low Vision Examination, Follow-up Visits, Prescribed Optical Devices such as high-powered spectacle, magnifiers and telescope)</i>	Comprehensive low vision examination once every 5 years, including 4 follow-up visits in any 5-year period.	<i>Low Vision Exam</i> 100%  Not subject to payment of the Annual Deductible.	<i>Low Vision Exam</i> 80% of the billed charge
		<i>Other Low Vision Services</i> 50%	<i>Other Low Vision Services</i> 50% of the billed charge

<b>Vision Care Service</b>	<b>Frequency of Service</b>	<b>Network Benefit</b>	<b>Non-Network Benefit</b>
<i>Eyeglass Lenses</i>	Once per year.		
• <i>Single Vision</i>		50%	50% of the billed charge
• <i>Bifocal</i>		50%	50% of the billed charge
• <i>Trifocal</i>		50%	50% of the billed charge
• <i>Lenticular</i>		50%	50% of the billed charge

<b>Vision Care Service</b>	<b>Frequency of Service</b>	<b>Network Benefit</b>	<b>Non-Network Benefit</b>
<i>Eyeglass Frames</i>	Once per year.		
• <i>Eyeglass frames with a retail cost up to \$130.</i>		50%	50% of the billed charge
• <i>Eyeglass frames with a retail cost of \$130 - 160.</i>		50%	50% of the billed charge
• <i>Eyeglass frames with a retail cost of \$160 - 200.</i>		50%	50% of the billed charge
• <i>Eyeglass frames with a retail cost of \$200 - 250.</i>		50%	50% of the billed charge

• <i>Eyeglass frames with a retail cost greater than \$250.</i>		50%	50% of the billed charge
---	--	-----	--------------------------

<b>Vision Care Service</b>	<b>Frequency of Service</b>	<b>Network Benefit</b>	<b>Non-Network Benefit</b>
<i>Contact Lenses</i>	Limited to a 12 month supply.		
• <i>Covered Contact Lens Selection</i>		50%	50% of the billed charge
• <i>Non-Selection Contact Lenses</i>		50%	50% of the billed charge
• <i>Necessary Contact Lenses</i>		50%	50% of the billed charge

## 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. Non-prescription items (e.g. Plano lenses).
3. Replacement or repair of lenses and/or frames that have been lost or stolen.
4. Optional Lens Extras not listed in *Section 1: Benefits for Vision Care Services*.
5. Missed appointment charges.
6. Applicable sales tax charged on Vision Care Services.
7. 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 Pediatric Vision Care Services

When obtaining Vision Care Services from a non-Network Vision Care Provider, you will be required to pay all billed charges directly to your Vision Care Provider. You may then seek reimbursement from us. Information about claim timelines and responsibilities in the *Certificate* in *Section 5: How to File a Claim* applies to Vision Care Services provided under this Rider, except that when you submit your claim, you must provide us with all of the information identified below.

### Reimbursement for Vision Care Services

To file a claim for reimbursement for Vision Care Services rendered by a non-Network Vision Care Provider, or for Vision Care Services covered as reimbursements (whether or not rendered by a [Spectera Eyecare Networks] [Network] Vision Care Provider or a non-Network Vision Care Provider), 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 [Spectera Eyecare Networks] [Network] Vision Care Provider on a covered-in-full basis, subject to payment of any applicable Copayment.

**[Spectera Eyecare Networks]** - any optometrist, ophthalmologist, optician or other person designated by us who provides Vision Care Services for which Benefits are available under the Policy.]

**Vision Care Provider** - any optometrist, ophthalmologist, optician or other person who may lawfully provide Vision Care Services.

**Vision Care Service** - any service or item listed in this Rider in *Section 1: Benefits for Pediatric Vision Care Services*.

## Notice of Change to Exhibit 2

Effective [\_\_\_\_\_], the following provision(s) included in Exhibit 2 of this Policy are replaced by the provision(s) shown below.

*Insert new or revised Eligibility conditions in A and B below.*

*[<sup>1</sup>Applies to plans offered OFF the Exchange.] [<sup>2</sup>Applies to SHOP plans.]*

- [1.] **[Eligibility.** The eligibility rules are [<sup>1</sup>established by the Enrolling Group] [<sup>2</sup>verified by the SHOP Exchange]. [<sup>1</sup>The following eligibility rules are in addition to the eligibility rules specified in the Employer Application and/or in *Section 3: When Coverage Begins* of the Certificate of Coverage:

*[Variable to add waiting or probationary period timeframe as determined by the enrolling group. The waiting period for an otherwise eligible individual to enroll will not exceed 90 days, in accordance with § 2708 of the Affordable Care Act.]*

A. The waiting or probationary period for newly Eligible Persons is as follows:

[\_\_\_\_\_]]

*<sup>1</sup>Insert new or revised Open Enrollment Period applicable only to Off Exchange plans. <sup>2</sup>Include timeframes agreed upon between the enrolling group and us.*

- [2.] [<sup>1</sup>**Open Enrollment Period.** An Open Enrollment Period of at least 31 days will be provided by the Enrolling Group during which Eligible Persons may enroll for coverage. The Open Enrollment Period will be provided on [<sup>2</sup>an annual basis] [<sup>2</sup>a quarterly basis] [<sup>2</sup>\_\_\_\_\_].]

*Insert new or revised Effective Date for Eligible Persons.*

*[<sup>1</sup>Insert the actual effective date. For SHOP plans this will always be the 1st day of the Plan Year.*

*<sup>2</sup>Always include for SHOP plans. The other options may be included for Off Exchange plans. <sup>3</sup>Include when effective date is last day of the waiting period. <sup>4</sup>Included when effective date is the 1st day of the month following the waiting period. <sup>5</sup>Included when effective date is the date the person joins the enrolling group. <sup>6</sup>Included when effective date is the 1st day of the month following the date the person joins the enrolling group. <sup>7</sup>Included when effective date is another date, as determined by the enrolling group.]*

- [3.] [**Effective Date for Eligible Persons.** The effective date of coverage for Eligible Persons who are eligible on the effective date of this Policy is [<sup>1</sup>\_\_\_\_\_].]

For an Eligible Person who becomes eligible after the effective date of this Policy, his or her effective date of coverage is [<sup>2</sup>the date verified by the SHOP Exchange][<sup>3</sup>The day following the last day of the required waiting period.] [<sup>4</sup>the first day of the month following the last day of the required waiting period.] [<sup>5</sup>the date the Eligible Person joins the Enrolling Group.] [<sup>6</sup>the first day of the month following the date the Eligible Person joins the Enrolling Group.][<sup>7</sup>as determined by the Enrolling Group, \_\_\_\_\_.] Any required waiting period will not exceed 90 days.]