Certificate of Coverage

EPO Plan

for

State of Maryland-State Law Enforcement Officers Labor Alliance

Group Number: 716451
Effective Date: July 1, 2013 through December 31, 2013

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Introduction

We are pleased to provide you with this Certificate of Coverage (COC). This COC describes your Benefits, as well as your rights and responsibilities, under the Plan.

How to Use this Document

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

We especially encourage you to review the Benefit limitations of this COC by reading Section 1: What's Covered--Benefits and Section 2: What's Not Covered--Exclusions. You should also carefully read Section 9: General Legal Provisions to better understand how this COC and your Benefits work. You should call the Claims Administrator if you have questions about the limits of the coverage available to you.

Many of the sections of the COC 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 COC and any attachments in a safe place for your future reference.

Please be aware that your Physician does not have a copy of your COC and is not responsible for knowing or communicating your Benefits.

To continue reading, go to right column on this page.

Information about Defined Terms

Because this COC is 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 10: Glossary of Defined Terms. You can refer to Section 10 as you read this document to have a clearer understanding of your COC.

When we use the words "we", "us", and "our" in this document, we are referring to the Plan Sponsor. When we use the words "you" and "your" we are referring to people who are Covered Persons as the term is defined in Section 10: Glossary of Defined Terms.

Your Contribution to the Benefit Costs

The Plan may require the Participant to contribute to the cost of coverage. Contact your benefits representative for information about any part of this cost you may be responsible for paying.

Customer Service and Claims Submittal

Please make note of the following information that contains Claims Administrator department names and telephone numbers.

Customer Service Representative (questions regarding Coverage or procedures): As shown on your ID card.

Prior Notification: As shown on your ID card.

Mental Health/Substance Use Disorder Services Designee: As shown on your ID card.

To continue reading, go to left column on next page.

Claims Submittal Address:

United HealthCare Services, Inc.
Attn: Claims
P.O. Box 740800
Atlanta, GA 30374-0800

Requests for Review of Denied Claims and Notice of Complaints:

Name and Address For Submitting Requests:

United HealthCare Services, Inc.
P.O. Box 30432
Salt Lake City, UT 84130-0432

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Section 1: What's Covered--Benefits

This section provides you with information about:

- Accessing Benefits.
- Copayments and Eligible Expenses.
- Annual Deductible, Out-of-Pocket Maximum and Maximum Plan Benefit.
- Covered Health Services. We pay Benefits for the Covered Health Services described in this section unless they are listed as not covered in Section 2: What's Not Covered--Exclusions.
- Covered Health Services that require you or your provider to notify the Claims Administrator before you receive them. In general, Network providers are responsible for notifying the Claims Administrator before they provide certain health services to you.

Accessing Benefits

You must select or we will assign a Primary Physician who will provide or coordinate all of the Covered Health Services you receive. For details, see Section 3: Obtaining Benefits.

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

To continue reading, go to right column on this page.

you are enrolled under the Plan. As a result, they may bill you for the entire cost of the services you receive.

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

- Covered Health Services are received while the Plan is in effect.
- Covered Health Services are received prior to the date that any of the individual termination conditions listed in Section 8: When Coverage Ends occurs.
- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements specified in the Plan.

Copayment

Copayment is the amount you pay each time you receive certain Covered Health Services. For a complete definition of Copayment, see Section 10: Glossary of Defined Terms. Copayment amounts are listed on the following pages next to the description for each Covered Health Service. Please note that when Copayments are calculated as a percentage (rather than as a set dollar amount) the percentage is based on Eligible Expenses.

Eligible Expenses

Eligible Expenses for Covered Health Services, incurred while the Plan is in effect, are determined by us or by our designee. In almost all cases our designee is the Claims Administrator. For a complete definition of Eligible Expenses that describes how payment is determined, see Section 10: Glossary of Defined Terms.

We have delegated to the Claims Administrator the discretion and authority to initially determine on our behalf whether a treatment or supply is a Covered Health Service and how the Eligible Expense will be determined and otherwise covered under the Plan.

To continue reading, go to left column on next page.

When you receive Covered Health Services from Network providers, you are not responsible for any difference between the Eligible Expenses and the amount the provider bills. (When you receive Covered Health Services from non-Network providers, 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.)

Notification Requirements

In general, Network providers are responsible for notifying the Claims Administrator before they provide these services to you. There are some Benefits, however, for which you are responsible for notifying the Claims Administrator.

Special Substance Use Disorder Programs and Services

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Administrator may become available to you as part of your Substance Use Disorder Services benefit. The Mental Health 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 Substance Use Disorder which may not otherwise be covered under this Plan. You must be referred to such programs through the Mental Health/Substance Use Disorder Administrator, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such program or service is at the discretion of the Covered Person and is not mandatory.

To continue reading, go to right column on this page.

Special Note Regarding Medicare

If you are enrolled for Medicare on a primary basis (Medicare pays before we pay Benefits under the Plan), the notification requirements described in this COC 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 notify the Claims Administrator before receiving Covered Health Services.

To continue reading, go to left column on next page.

Payment Information

Payment Term	Description	Amounts
Annual Deductible	The amount you pay for Covered Health Services before you are eligible to receive Benefits.	No Annual Deductible.
Out-of-Pocket Maximum	The maximum you pay, out of your pocket, in a Plan year for Copayments.	No Out-of-Pocket Maximum.
Maximum Plan Benefit	There is no dollar limit to the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan.	No Maximum Plan Benefit.

Benefit Information

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
1. Acupuncture Services Acupuncture services for pain therapy when the service is performed by a Network provider in the provider's office. Covered Health Services include treatment of nausea as a result of: • Nausea and vomiting from chemotherapy. • Nausea and vomiting from Pregnancy. • Post-operative dental pain. • A comprehensive treatment program for chronic pain.	No Copayment
2. Allergy Care Coverage includes skin testing, Physician services and injections. No copay applies if office visit is not billed.	$15 per visit Primary Care Physician $25 per visit Specialist No Copayment applies when a Physician charge is not assessed.

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
3. Ambulance Services – (Medical Emergency and Non-Emergency) Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be performed. Air transportation is covered if ground transportation is impossible or would put your life or health in serious jeopardy. The Plan also covers transportation provided by a licensed professional ambulance, other than air ambulance, (either ground or air ambulance, as the Claims Administrator determines appropriate) between facilities when the transport is: • 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; or • from an acute facility to a sub-acute setting.	*Ground Transportation:* No Copayment *Air Transportation:* No Copayment

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
4. Amino Acid-Based Elemental Formula The Plan pays Benefits for amino acid-based elemental formula, regardless of delivery method, for the diagnosis and treatment of: • Immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins. • Severe food protein induced Enterocolitis Syndrome. • Eosinophillic disorders (as evidenced by results of a biopsy). • Impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length and motility of the gastrointestinal tract.	No Copayment
5. Cancer Resource Services We will arrange for access to certain of our Network providers that participate in the Cancer Resource Services program for the provision of oncology services. We may refer you to Cancer Resource Services, or you may self refer to Cancer Resource Services by calling 866-936-6002. In order to receive the highest level of Benefits, you must contact Cancer Resource Services prior to obtaining Covered Health Services. The oncology services include Covered Health Services and supplies rendered for the treatment of a condition that has a primary or suspected diagnosis relating to cancer. In order to receive Benefits under this program, Cancer Resource Services must provide the proper notification to the Network provider performing the services. This is true even if you self refer	No Copayment

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
to a Network provider participating in the program. When these services are not performed in a Cancer Resource Services facility, Benefits will be paid the same as Benefits for *Hospital-Inpatient Stay*, *Outpatient Surgery*, *Diagnostic and Therapeutic Services*, *Physician's Office Services*, and *Professional Fees for Surgical and Medical Services* stated in this (Section 1: What's Covered--Benefits).	
6. Chiropractic Treatment The Plan pays Benefits for chiropractic treatment when provided by a licensed chiropractor.	No Copayment
7. Cleft Lip/Palate The Plan pays Benefits for orthodontic services, oral surgery and otologic, audiological and speech therapy/language for a Dependent child in connection with cleft lip or cleft palate or both. Services must be provided by or under the direction of a Physician.	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Rehabilitation Services and Outpatient Surgery, Diagnostic and Therapeutic Services.
8. Clinical Trials Benefits are available for patient costs incurred during participation in clinical trials for prevention, early detection and treatment studies on cancer or treatment of other life-threatening conditions when ordered, provided or arranged by a Physician and authorized in advance by the Plan. The treatment must be conducted in a Phase I, Phase II, Phase III or Phase IV clinical trial.	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, and Outpatient Diagnostic and Therapeutic Services.

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
The clinical trial must be approved by one of the following: • One of the National Institutes of Health (NIH); • An NIH cooperative group or a NIH center; • The Food and Drug Administration (FDA) in the form of an investigational new drug application; • The Federal Department of Veterans Affairs; or • An institutional review board of an institution in the State of Maryland that has a multiple project assurance contract approved by the Office of Protection from Research Risks of the NIH. Coverage applies only if all of the following are true: • The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise; • There is no clearly superior, non-investigational treatment alternative; • The available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as effective as the non-investigational alternative; and • The Covered Person and his/her Physician conclude that participation in the clinical trial would be appropriate. Coverage is provided only for the cost of Covered Health Services that is incurred as a result of the treatment being provided to the	

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
Covered Person for purposes of a clinical trial. Coverage is not provided for the cost of non-health care services that a patient may be required to receive as a result of the treatment being provided for purposes of a clinical trial, costs associated with managing the research associated with the clinical trial, or the cost of any investigational drug or device. However, Coverage does include patient cost incurred for drugs and devices that have been approved for sale by the FDA whether or not the FDA has approved the drug or device for use in treating the patient's particular condition, to the extent that the drugs or devices are not paid for by the manufacturer, distributor, or provider of that drug or device.	
9. Congenital Heart Disease The Plan pays Benefits for Congenital Heart Disease (CHD) services ordered by a Physician and received at a CHD Resource Services program. Benefits are available for the following CHD services: • Outpatient diagnostic testing; • Evaluation; • Surgical interventions; • Interventional cardiac catheterizations (insertion of a tubular device in the heart); • Fetal echocardiograms (examination, measurement and diagnosis of the heart using ultrasound technology); and • Approved fetal interventions. CHD services other than those listed above are excluded from	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, and Outpatient Diagnostic and Therapeutic Services.

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
coverage, unless determined by United Resource Networks or Care Coordination[SM] to be proven procedures for the involved diagnoses. Contact United Resource Networks at (888) 936-7246 or Care Coordination[SM] at the toll-free number on your ID card for information about CHD services. If you receive Congenital Heart Disease services from a facility that is not a Designated Facility, Benefits will be paid the same as Benefits for *Hospital-Inpatient Stay*, *Outpatient Surgery*, *Diagnostic and Therapeutic Services*, *Physician's Office Services*, and *Professional Fees for Surgical and Medical Services* stated in this (Section 1: What's Covered--Benefits).	
10. Dental Services - Accident Only Dental services when all of the following are true: • Treatment is necessary because of accidental damage. • Dental services are received from a Doctor of Dental Surgery, "D.D.S." or Doctor of Medical Dentistry, "D.M.D.". • The dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident.	$25 per visit

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
Benefits are available only for treatment of a sound, natural tooth. The Physician or dentist must certify that the injured tooth was: • A virgin or unrestored tooth, or • A tooth that has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, is not a dental implant and functions normally in chewing and speech. Dental services for final treatment to repair the damage must be both of the following: • Started within three months of the accident; and • Completed within 12 months of the accident. Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered an "accident". Benefits are not available for repairs to teeth that are injured as a result of such activities.	

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
Dental Services - Hospital and Alternate Facility Health Services Related to Dental Care The Plan covers dental anesthesia and associated Hospital or Alternate Facility charges in conjunction with dental care provided to a Covered Person if the Covered Person: • Is a child under the age of seven; • Is developmentally disabled; • Has one or more physical or mental conditions that require admission to a Hospital or Alternate Facility and general anesthesia for successful dental treatment; • Is an individual for whom a superior result can be expected from dental care provided under general anesthesia; or • Is an emotionally disturbed child 17 years of age or younger with severe dental needs of such magnitude that treatment should not be delayed or deferred. Such health services must be provided under the direction of a Physician or dentist. Coverage does not include expenses for the diagnosis or treatment of dental disease. **Notify the Claims Administrator** Please remember that you must notify the Claims Administrator at the telephone number on your ID card as soon as possible, but at least five business days before follow-up (post-Emergency) treatment begins. (You do not have to provide notification before the initial Emergency treatment.)	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, and Outpatient Diagnostic and Therapeutic Services.

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses

11. Diabetes Services

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

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

Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes.

Diabetes Self-Management Items

Insulin pumps and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person including, but not limited to:

- Blood glucose monitors;
- Insulin syringes with needles;
- Blood glucose and urine test strips;
- Ketone test strips and tablets; and
- Lancets and lancet devices.

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

Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be paid the same as those stated under each Covered Health Service category in this section.

Diabetes Self-Management Items

Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under Durable Medical Equipment.

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
Insulin pumps are subject to all the conditions of coverage stated under Durable Medical Equipment in this section. Benefits for diabetes equipment that meet the definition of Durable Medical Equipment are subject to the limit stated under *Durable Medical Equipment* in this section.	
12. Durable Medical Equipment Durable Medical Equipment that meets each of the following criteria: • Ordered or provided by a Physician for outpatient use; • Used for medical purposes; • Not consumable or disposable; and • Not of use to a person in the absence of a disease or disability. If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the most cost-effective piece of equipment. Examples of Durable Medical Equipment include: • Equipment to assist mobility, such as a standard wheelchair; • A standard Hospital-type bed; • Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks); • Delivery pumps for tube feedings (including tubing and	No Copayment

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
connectors); • Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an Injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. Dental braces are also excluded from coverage; • Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditions, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage); and • Insulin pumps and all related necessary supplies as described under *Diabetes Services* in this section. • Breast pump. The Plan also covers tubings, nasal cannulas, connectors and masks used in connection with Durable Medical Equipment. We provide Benefits only for a single purchase (including repair/replacement) of a type of Durable Medical Equipment if, upon review, the repair/replacement is deemed needed. Shoe orthotics are covered and are limited to one pair per plan year. We and the Claims Administrator will decide if the equipment should be purchased or rented. You must purchase or rent the Durable Medical Equipment from the vendor the Claims Administrator identifies.	

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
13. Emergency Health Services Services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility. You will find more information about Benefits for Emergency Health Services in (Section 3: Obtaining Benefits). If you are admitted as an inpatient to a Network Hospital directly from the emergency room, you will not have to pay this Copay. The Benefits for an Inpatient Stay in a Network Hospital will apply instead.	*Medical Emergency:* $50 per visit for Physician charges and a $50 per visit for facility charges
If criteria is not met for a Medical Emergency, the Plan coverage is 50% after $50 per visit for the emergency room facility and $50 per visit for the emergency Physician.	*Non-Emergency:* 50% after you pay $50 per visit for Physician charges and $50 per visit for facility charges
14. Hearing Care and Hearing Aids Benefits are available for the following Covered Health Services when received from a provider in the provider's office: • Routine hearing exams up to one exam every 36 months; • Hearing exams in case of Injury or Sickness; or • Hearing aids which are required for the correction of a hearing	***Hearing Exam*** *Primary Physician:* $15 per visit *Specialist Physician:* $25 per visit

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness).	***Hearing Aid*** No Copayment

Please note that Benefits are available for adult hearing exams or adult hearing aids. Coverage is provided for hearing aids for a minor child if the hearing aids are prescribed, fitted and dispensed by a licensed audiologist. For purposes of this benefit, "hearing aid" means a device that:

- Is of design and circuitry to optimize audibility and listening skills in the environment commonly experienced by children; and
- Is non-disposable.

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 for hearing aids are limited as follows:

- Up to one hearing aid for each impaired ear every 36 months.
- Up to $5,000 for each hearing impaired ear every 36 months.

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
15. Home Health Care Covered Health Services include services received from a Home Health Agency that meet all of the following: • Except for the services required by state law listed below, services that consist of a plan of treatment that is established and approved in writing by the Covered Person's Physician where institutionalization of the Covered Person would be required if Home Health Care was not provided; • Are provided in the Covered Person's home by a person licensed under the Health Occupations Article of the Maryland Code; • Ordered by a Physician; and • Provided in your home by a registered nurse, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse. In accordance with state law, Home Health Care services are also available for the following: • One home visit scheduled to occur within 24 hours after discharge from the Hospital or outpatient health care facility for a patient who received less than 48 hours of inpatient hospitalization following a mastectomy or the surgical removal of a testicle, or who undergoes such procedures on an outpatient basis. The Plan will provide coverage for an additional home visit if prescribed by the patient's attending Physician; • One home visit and an additional home visit when prescribed by	No Copayment

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
a Physician for a mother and newborn child following discharge from a Hospital **prior to** a 48 hour Inpatient Stay for an uncomplicated delivery or 96 hours for a cesarean delivery. Such newborn home visits are not subject to any Copayment; or • One home visit when prescribed by a Physician for a mother and newborn child following discharge from a Hospital **after** a 48 hour Inpatient Stay for an uncomplicated normal delivery or 96 hours for a cesarean delivery. Such a home visit is not subject to any Copayment. Such home visits shall be provided with the following conditions: • They will comply with generally accepted standards of nursing practice for home care of a mother and newborn child; • They will be provided by registered nurse with at least one year of experience in maternal and child health nursing or community health nursing with an emphasis on maternal and child health; or • They will include any services required by the attending health care provider. Benefits are available only when the Home Health Agency services are provided on a part-time, Intermittent Care schedule and when skilled care is required. The Claims Administrator will decide if Skilled Care is needed by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.	

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
Benefits are limited to 120 visits per plan year. One visit equals four hours of Skilled Care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.	
16. Hospice Care Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social and spiritual care for the terminally ill person, and short-term grief counseling for immediate family members. Benefits are available when hospice care is received from a licensed hospice agency. Please contact the Claims Administrator for more information regarding guidelines for hospice care. You can contact the Claims Administrator at the telephone number on your ID card.	No Copayment
17. Hospital - Inpatient Stay Inpatient Stay in a Hospital. Benefits are available for: • Services and supplies received during the Inpatient Stay; and • Room and board in a Semi-private Room (a room with two or more beds). Benefits for Physician services are described under *Professional Fees for Surgical and Medical Services.*	No Copayment

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
18. Infertility Services The Plan pays Benefits for the treatment of infertility for: • A Covered Person who meets the definition of Infertility; • Ovulation induction (excludes injectable medications, covered under the carved out pharmacy benefit plan); • Insemination procedures: Artificial insemination (AI) and Intra Uterine Insemination (IUI) limited to three (3) cycles per Covered Person's lifetime; and • One reversal of voluntary sterilization per Covered Person's lifetime. After the reversal of voluntary sterilization, the Covered Person must meet the infertility criteria or above in vitro fertilization criteria prior to coverage of these services. If the Covered Person's Physician stipulates that the covered once per lifetime reversal of sterilization is not technically possible, coverage for in vitro may be considered if other requirements above are met. In vitro fertilization benefits are covered for married Covered Persons when services are received at an outpatient facility which conforms to the guidelines set forth by the American College of Obstetricians and Gynecologists for in vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in vitro fertilization. Covered in vitro fertilization benefits are limited to three (3) in vitro fertilization attempts per live birth and $100,000 per lifetime. Artificial Insemination is covered for a maximum of three (3) cycles per Covered Person's lifetime.	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, and Outpatient Diagnostic and Therapeutic Services.

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
Covered in vitro fertilization benefits will be provided only when: I. The Covered Person's cocytes are fertilized with the Covered Person's Spouse's sperm; II. The Covered Person and the Covered Person's Spouse have had a history of infertility during the most recent 2 years duration; or III. The infertility is associated with any of the following medical conditions: 1. endometriosis; 2. exposure in utero to diethyistibestrol, commonly known as DES; 3. blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectmoy); or 4. abnormal male factors, including oliggospermia, contributing to the infertility, and; IV. The Covered Person has been unable to attain a successful Pregnancy through a less costly infertility treatment for which coverage is available under this COC. Copayments and Coinsurance will be applied to the same extent as other covered infertility services. Prescribed medications will be covered that are associated with an in vitro fertilization procedure authorized by the Claims Administrator. Covered Persons who have the State Pharmacy plan may choose to use their pharmacy benefit for the coverage of the outpatient IVF medication. In order to seek reimbursement from the Claims Administrator the Covered Person will need to submit a claim form. Upon request the pharmacy will provide you with the proper, proof	

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
of loss. The Covered Person must remit a receipt as provided by the pharmacy, complete the National Drug Code, Prescription Number and days' supply quantity, prescribing physician's DEA number and total charges. Benefits for Artificial Insemination are limited to three attempts and must be done (when medically appropriate) before IVF attempts will be covered. Benefits for IVF services are limited to $100,000 per Covered Person during the entire period you are covered under the plan. All IVF charges which include embryology count toward lifetime maximum. Please note that the Plan does not cover sex selection services.	
19. Injections Received in a Physician's Office Benefits are available for injections received in a Physician's office when no other health service is received, for example allergy immunotherapy.	*Primary Physician:* $15 per visit *Specialist Physician:* $25 per visit No Copayment applies when a Physician charge is not assessed. No Copayment applies for allergy

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
	injections without a Physician's office visit.
20. Kidney Resource Services The Plan pays Benefits for Comprehensive Kidney Solution (CKS) that covers both chronic kidney disease and End Stage Renal Disease (ESRD) disease provided by Designated Facilities participating in the Kidney Resource Services (KRS) program. Designated Facility is defined in (Section 10: Glossary of Defined Terms). In order to receive Benefits under this program, KRS must provide the proper notification to the Network provider performing the services. This is true even if you self refer to a Network provider participating in the program. Notification is required: • Prior to vascular access placement for dialysis; and • Prior to any ESRD services. You or a covered Dependent may: • be referred to KRS by the Claims Administrator; or • call KRS toll-free at (888) 936-7246 and select the KRS prompt.	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, and Outpatient Surgery, Diagnostic and Therapeutic Services.

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
When these services are not performed in a Kidney Resource Services facility, Benefits will be paid the same as Benefits for *Hospital-Inpatient Stay*, *Outpatient Surgery*, *Diagnostic and Therapeutic Services*, *Physician's Office Services*, and *Professional Fees for Surgical and Medical Services* stated in this (Section 1: What's Covered--Benefits).	
21. Maternity Services Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications. There are special prenatal programs to help during Pregnancy. They are completely voluntary and there is no extra cost for participating in the programs. To sign up, you should notify the Claims Administrator during the first trimester, but no later than one month prior to the anticipated childbirth. We will pay Benefits for an Inpatient Stay of at least: • 48 hours for the mother and newborn child following a normal vaginal delivery; and • 96 hours for the mother and newborn child following a cesarean section delivery. If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier.	Depending upon where the Covered Health Service is provided, Benefits for Maternity Services will be the same as those stated under each Covered Health Service category in this section.

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
Newborn Care The Plan pays Benefits for circumcision, including circumcision performed by a mohel recognized under the laws of Judaism.	
22. Medical Foods and Tube Feeding Supplies Medical Foods are covered when determined to be the sole source of nutrition including amino acid-based elemental formula as described earlier in this section. Sole source means that the Participant is unable to tolerate (swallow or absorb) any other form of oral nutrition or that the nutrition is the Participant's primary source of sufficient caloric/nutrient intake to achieve or maintain appropriate body weight. Medical foods may be obtained with a prescription (restricted, not over-the-counter) or without a prescription (over-the-counter). Tube feeding supplies are provided for feeding pump and bag and tubing and related supplies for feeding when it is determined that the food product is the sole source of nutrition or for treatment of Inherited Metabolic Disease(s), unless otherwise noted in Section8, *Exclusions*. Sole source means that the Participant is unable to tolerate (swallow or absorb) any other form of oral nutrition or that the nutrition is the Participant's primary source of sufficient caloric/nutrient intake to achieve or maintain appropriate body weight.	No Copayment

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
23. Mental Health Services Mental Health Services include those received on an inpatient basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility. Benefits include: • diagnostic evaluations and assessment; • treatment planning; • referral services; • medication management; • individual, family, therapeutic group and provider-based case management services; and • crisis intervention. Benefits include the following services provided on an inpatient basis: • Inpatient Hospitalization; • Partial Hospitalization/Day Treatment; and • Services at a Residential Treatment Facility. Benefits include the following services provided on an outpatient basis: • Intensive Outpatient Treatment.	**Hospital – Inpatient Stay** No Copayment **Physician's Outpatient Services** $15 per visit For Residential Crisis and Outpatient Facility Services, coverage is 100%. No Copayment applies

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
We provide coverage for all medically necessary residential crisis services. Residential crisis services means intensive mental health and support services that are: • provided to a child or an adult with a mental illness who is experiencing or is at risk of a 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 individual'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. The Mental Health/Substance Use Disorder Designee, who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis. Referrals to a Mental Health Services provider are at the discretion of the Mental Health/Substance Use Disorder Designee, who is responsible for coordinating all of your care. Mental Health Services must be authorized and overseen by the Mental Health/Substance Use Disorder Designee. Contact the Mental Health/Substance Use Disorder Designee regarding Benefits for Mental Health Services.	

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
24. Neurobiological Disorders – Mental Health Services for Autism Spectrum Disorders Psychiatric services for Autism Spectrum Disorders that are both of the following: • Provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider. • Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning. These Benefits describe only the psychiatric component of treatment for Autism Spectrum Disorders. Medical treatment of Autism Spectrum Disorders is a Covered Health Service for which Benefits are available under the applicable medical Covered Health Services categories as described in this section. Benefits include the following services provided on either an outpatient or inpatient basis: • Diagnostic evaluations and assessment; • Treatment planning; • Referral services; • Medication management; • Inpatient/24-hour supervisory care;	**Hospital – Inpatient Stay** No Copayment **Physician's Outpatient Services** $15 per visit For Residential Crisis and Outpatient Facility Services, coverage is 100%. No Copayment applies

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
• Partial Hospitalization/Day Treatment; • Intensive Outpatient Treatment; • Services at a Residential Treatment Facility; • Individual, family, therapeutic group and provider-based case management services; and • Crisis intervention. Autism Spectrum Disorder services must be authorized and overseen by the Mental Health/Substance Use Disorder Designee. Contact the Mental Health/Substance Use Disorder Designee regarding Benefits for Neurobiological Disorders - Autism Spectrum Disorder Services.	
25. Nutritional Counseling The Plan will pay for Covered Health Services for medical education services provided in a Physician's office by an appropriately licensed or healthcare professional when: • education is required for a disease in which patient self-management is an important component of treatment; and • there exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional. Some examples of such medical conditions include: • coronary artery disease;	**Preventive Services** No Copayment **Non-Preventive Services** Primary Physician: $15 per visit Specialist Physician: $25 per visit

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
• congestive heart failure; • severe obstructive airway disease; • gout (a form of arthritis); • renal failure; • phenylketonuria (a genetic disorder diagnosed at infancy); and • hyperlipidemia (excess of fatty substances in the blood). When nutritional counseling services are billed as a preventive care service, these services will be paid as described under *Preventive Care Services* in this section.	
26. Obesity Surgery The Plan covers surgical treatment of obesity provided by or under the direction of a Physician when the treatment of morbid obesity is: • Recognized by the National Institutes of Health (NIH) as effective for the long-term reversal of morbid obesity; and • Consistent with criteria approved by the National Institutes of Health (NIH). For purposes of this coverage, the term "morbid obesity" is defined as a body mass index that is: • Greater than 40 kilograms per meter squared; or • Equal to or greater than 35 kilograms per meter squared with a co-morbid medical condition including hypertension, a	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, and Outpatient Surgery, Diagnostic and Therapeutic Services.

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
cardiopulmonary condition, sleep apnea or diabetes.	
27. Ostomy Supplies Benefits for ostomy supplies include only the following: • Pouches, face plates and belts; • Irrigation sleeves, bags and catheters; and • Skin barriers. Benefits are not available for gauze, adhesive, adhesive remover, deodorant, pouch covers, or other items not listed above.	No Copayment
28. Outpatient Surgery, Diagnostic and Therapeutic Services ***Outpatient Surgery*** Covered Health Services for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility. Benefits under this section include only the facility charge and the charge for supplies and equipment. Benefits for the surgeon fees related to outpatient surgery are described under *Professional Fees for Surgical and Medical Services* below. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.	No Copayment

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
Outpatient Diagnostic Services Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including: • Lab and radiology/X-ray. • Mammography testing. Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below. This section does not include Benefits for CT scans, Pet scans, MRIs, or nuclear medicine, which are described immediately below.	***For lab and radiology/ X-ray:*** No Copayment ***For mammography testing:*** No Copayment
Outpatient Diagnostic/Therapeutic Services - CT Scans, Pet Scans, MRI and Nuclear Medicine Covered Health Services for CT scans, Pet scans, MRI, and nuclear medicine received on an outpatient basis at a Hospital or Alternate Facility. Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees.	No Copayment

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
Outpatient Therapeutic Treatments Covered Health Services for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including dialysis, intravenous chemotherapy or other intravenous infusion therapy, and other treatments not listed above. Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.	No Copayment
29. Pharmaceutical Products - Outpatient The Plan pays for Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home. Examples of what would be included under this category are antibiotic injections in the Physician's office or inhaled medication in an Urgent Care Center for treatment of an asthma attack. Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by the Claims Administrator), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy.	No Copayment

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
30. Physician's Office Services Covered Health Services for the diagnosis and treatment of a Sickness or Injury received in a Physician's office.	*Primary Physician:* $15 per visit *Specialist Physician:* $25 per visit No Copayment applies when no Physician charge is assessed.
31. Preventive Care Services The Plan pays Benefits for Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law: • evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force; • immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; • with respect to infants, children and adolescents, evidence-	No Copayment covered at 100%

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and • with respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. • breast pump. Preventive care Benefits defined under the Health Resources and Services Administration (HRSA) requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Benefits for breast pumps also include the cost of purchasing one breast pump per Pregnancy in conjunction with childbirth. Benefits are only available if breast pumps are obtained from a participating Network DME provider. Covered Health Services for preventive care include: ***Well Child:*** • Child wellness services and related lab work are limited to twelve (12) visits per child up to three (3) years of age and one (1) visit per year for ages three (3) through twenty-one (21). • Office visits and related expenses for childhood and adolescent immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control; excluding Immunizations for travel.	

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
• Services for hereditary and metabolic newborn screening and follow-up visits from birth to four weeks of age including visits for the collection of samples before two weeks of age. • Universal hearing screening of newborns provided by a Hospital before discharge. • Services for age-appropriate screening tests for tuberculosis, anemia, lead toxicity, hearing and vision as determined by the American Academy of Pediatrics. • Physical examinations, developmental assessments, parental anticipatory guidance and laboratory tests considered necessary by the Physician for services described above. • HPV injections for boys and girls. • One flu shot per plan year. ***Well Adult:*** • Adult Physical exams and related lab work for ages twenty-two (22) and older. • One flu shot per plan year. • Shingles immunization. ***Well Man:*** • Prostate cancer screening. including digital rectal exams and prostate-specific antigen (PSA) blood tests: — Every 36 months for male Covered Persons who are between the ages of 40 and 75; — When used for the purpose of guiding patient management	

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
in monitoring the response to prostate cancer treatment; — When used for staging in determining the need for a bone scan in patients with prostate cancer; or — When used for Covered Persons who are at high risk for prostate cancer. • An annual Chlamydia screening test for men who have multiple risk factors. • Screening colonoscopy or sigmoidoscopy and other colorectal cancer screening tests in accordance with the latest screening guidelines issued by the American Cancer Society. "Multiple risk factors" means having a prior history of a sexually transmitted disease, new or multiple sex partners, inconsistent use of barrier contraceptives. "Chlamydia screening test" means any laboratory test that: • Specifically detects for infection by one or more agents of Chlamydia trachomatis; and • Is approved for this purpose by the federal Food and Drug Administration. ***Well Woman:*** • An annual OB-GYN exam. • Benefits for screening mammography include: — A baseline mammogram for women 35 to 39 years of age. — An annual mammogram for women age 40 or older.	

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
• Screening colonoscopy or sigmoidoscopy and other colorectal cancer screening tests in accordance with the latest screening guidelines issued by the American Cancer Society. • Cervical cancer screening. • Bone mineral density tests including a bone mass measurement (a radiologic or radioisotopic procedure, or other scientifically proven technology) for the prevention, diagnosis, and treatment of osteoporosis when the bone mass measurement is requested by a Physician, and: — You are an estrogen deficient individual at risk for osteoporosis; — You are an individual with a specific sign suggestive of spinal osteoporosis, including roentgenographic osteopenia or roentgenographic evidence suggestive of collapse, wedging, or ballooning of one or more thoracic or lumbar vertebral bodies, who is a candidate for therapeutic intervention or for an extensive diagnostic evaluation for metabolic bone disease; — You show a specific sign suggestive of spinal osteoporosis, including roentgenographic osteopenia or roentgenographic evidence suggestive of collapse, wedging, or ballooning of one or more thoracic or lumbar vertabral bodies and are a candidate for therapeutic intervention or for an extensive diagnostic evaluation for metabolic bone disease; — You are receiving long-term glucocorticoid (steroid) therapy; — You have hyperparathyroidism; or	

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
— You are being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy. • Contraceptive methods and counseling – IUD's and tubal ligations. • Breast pump. • Counseling for sexually transmitted infections. • Counseling and screening for human immune deficiency virus (HIV). • Screening and counseling for interpersonal and domestic violence. • Screening for gestational diabetes. • An annual Chlamydia screening test for women who are: — (i) younger than 20 years old who are sexually active, and — (ii) at least 20 years old who have multiple risk factors. • A Human Papillomavirus Screening Test at the testing intervals for cervical cytology screenings recommended for cervical cytology screenings by the American College of Obstetricians and Gynecologists. "Multiple risk factors" means having a prior history of a sexually transmitted disease, new or multiple sex partners, inconsistent use of barrier contraceptives, or cervical ectopy. "Chlamydia screening test" means any laboratory test that: • Specifically detects for infection by one or more agents of	

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
chlamydia trachomatis; and • Is approved for this purpose by the federal Food and Drug Administration. "Human Papillomavirus Screening Test" means any laboratory test that: • Specifically detects for infection by one or more agents of the human papillomavirus; and • Is approved for this purpose by the federal Food and Drug Administration.	
32. Private Duty Nursing - Outpatient The Plan covers private duty nursing care given on an outpatient basis by a licensed nurse such as a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.). Private duty nursing is nursing care that is provided to a patient on a one-to-one basis by licensed nurses in a home setting when any of the following are true: • No skilled services are identified; • Skilled nursing resources are available in the facility; • The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose; or • The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her	No Copayment

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
family. This includes nursing services provided on a home-care basis, whether the service is skilled or non-skilled independent nursing.	
33. Professional Fees for Surgical and Medical Services Professional fees for surgical procedures and other medical care received in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* above.	No Copayment
34. Prosthetic Devices External prosthetic devices that replace a limb or an external body part, limited to: • Artificial arms, legs, feet and hands; • Artificial eyes, ears and noses; • Speech aid prosthetics and tracheo-esophageal voice prosthetics; and • Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. Benefits include mastectomy bras and lymphedema stockings for the arm. Benefits are also provided for wigs that are required as a result of cancer Benefits for wigs are limited to $350 per lifetime. If more than one prosthetic device can meet your functional needs,	No Copayment

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
Benefits are available only for the most cost-effective 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 provided for the replacement of a type of prosthetic device if, upon review, the repair/replacement is deemed needed. Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body other than breast prostheses. Benefits are available for repairs and replacement, except that there are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices.	
35. Reconstructive Procedures Services for reconstructive procedures, when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The fact that physical appearance may change or improve as a result of a reconstructive procedure does not classify such surgery as a Cosmetic Procedure when a physical impairment exists, and the surgery restores or improves	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services and Prosthetic Devices.

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
function. Breast reduction is covered if determined to treat a physiological functional impairment or if coverage is required by the Women's Health and Cancer Rights Act of 1998. Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery or other procedures done to relieve such consequences or behavior as a reconstructive procedure. Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact the Claims Administrator at the telephone number on your ID card for more information about Benefits for mastectomy related services.	

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
36. Rehabilitation Services - Outpatient Therapy Short-term outpatient rehabilitation services for: • Physical therapy. • Occupational therapy. • Speech therapy. • Pulmonary rehabilitation therapy. • Cardiac rehabilitation therapy. Rehabilitation services must be performed by a licensed therapy provider, under the direction of a Physician. Benefits are available only for rehabilitation services that are expected to result in significant physical improvement in your condition. Please note that we will pay Benefits for speech therapy only when the speech impediment or speech dysfunction results from Injury, stroke or a Congenital Anomaly. Benefits are limited to: • 50 visits per plan year for physical, occupational and speech therapy combined. • 20 visits per plan year for pulmonary rehabilitation therapy. • 36 visits within a 12 week period per event for cardiac	*Occupational, Physical and Speech Therapy:* $25 per visit *Chiropractic Treatment and Cardiac and Pulmonary Rehabilitation Services:* No Copayment

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
rehabilitation therapy. Habilitative services for the treatment of a child with a congenital or genetic birth defect are covered for Dependent children under the age of 19 with no visit limits. Additional visits for speech therapy are available for a diagnosis of brain Injury (unlimited visits).	
37. Skilled Nursing Facility Services for an Inpatient Stay in a Skilled Nursing Facility. Benefits are available for: • Services and supplies received during the Inpatient Stay. • Room and board in a Semi-private Room (a room with two or more beds). Benefits are limited to 180 days per Plan year. Please note that Benefits are available only for the care and treatment of an Injury or Sickness that would have otherwise required an Inpatient Stay in a Hospital.	No Copayment
38. Substance Use Disorder Services Substance Use Disorder Services include those received on an inpatient basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.	**Hospital – Inpatient Stay** No Copayment **Physician's Outpatient Services**

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
Benefits include the following services provided on either an inpatient or outpatient basis: • Diagnosis evaluations and assessment; • Treatment planning; • Detoxification (sub-acute/non-medical); • Inpatient; • Referral services; • Medication management; • Individual, family and group therapeutic services; and • Crisis intervention. Benefits include the following services provided on an inpatient basis: • Inpatient Hospitalization. • Partial Hospitalization/Day Treatment. • Services at a Residential Treatment Facility. Benefits include the following services provided on an outpatient basis: • Intensive Outpatient Treatment. We provide coverage for all medically necessary residential crisis services. Residential crisis services means intensive mental health and support services that are: • provided to a child or an adult with a mental illness who is	$15 per visit For Residential Crisis and Outpatient Facility Services, coverage is 100%. No Copayment applies

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
experiencing or is at risk of a 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 individual'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. The Mental Health/Substance Use Disorder Designee, who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis. Referrals to a Substance Use Disorder Services provider are at the discretion of the Mental Health/Substance Use Disorder Designee, who is responsible for coordinating all of your care. Substance Use Disorder Services must be authorized and overseen by the Mental Health/Substance Use Disorder Designee. Contact the Mental Health/Substance Use Disorder Designee regarding Benefits for Substance Use Disorder Services.	
39. Telemedicine Services Covered Health Services delivered through the use of interactive audio, video, or other telecommunications or electronic technology by a Physician at a site other than the site at which the patient is located.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
Telemedicine does not include: • An audio-only telephone conversation between a health care provider and a patient; • An electronic mail message between a health care provider and a patient; or • A facsimile transmission between a health care provider and a patient.	
40. Temporomandibular Joint Dysfunction (TMJ) The Plan covers diagnostic and surgical and non-surgical treatment of conditions affecting the temporomandibular joint when provided by or under the direction of a Physician. Coverage includes necessary treatment required as a result of accident, trauma, a Congenital Anomaly, developmental defect, or pathology. Diagnostic treatment includes examination, radiographs and applicable imaging studies and consultation. Non-surgical treatment includes clinical examinations, oral appliances (orthotic splints), arthrocentesis and trigger-point injections. Benefits are provided for surgical treatment if all of the following are true: • There is clearly demonstrated radiographic evidence of significant joint abnormality. • Non-surgical treatment has failed to adequately resolve the	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, and Outpatient Diagnostic and Therapeutic Services.

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
symptoms. • Pain or dysfunction is moderate or severe. Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy, open or closed reduction of dislocations and TMJ implants. Please note that Benefits are not available for charges for services that are dental in nature. Benefits for an Inpatient Stay in a Hospital and Hospital-based Physician services are described in this section under *Hospital – Inpatient Stay* and *Physician Fees for Surgical and Medical Services*, respectively.	
41. Transplantation Services Covered Health Services for organ and tissue transplants when ordered by a Physician. Benefits are available to the donor and the recipient when the recipient is covered under this Plan, for any of the organ and tissue transplants listed below when the transplant meets the definition of a Covered Health Service and is not Experimental or Investigational, or Unproven: • Bone marrow (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service; • Heart;	No Copayment

- Heart/lung;
- Kidney;
- Kidney/pancreas;
- Liver;
- Liver/kidney;
- Lung/lobar lung;
- Multi-visceral;
- Pancreas;
- Small bowel; and
- Small bowel/liver.

Benefits are also available for cornea transplants that are provided by a Network Physician at a Network Hospital. We do not require that cornea transplants be performed at a Designated Facility.

Organ or tissue transplants or multiple organ transplants other than those listed above are excluded from coverage.

Under the Plan there are specific guidelines regarding Benefits for transplant services. Contact the Claims Administrator at the telephone number on your ID card for information about these guidelines.

Transportation and Lodging

The Claims Administrator will assist the patient and family with travel and lodging arrangements when services are received from a Designated Facility. Expenses for travel and lodging for the

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
transplant recipient and a companion are available under this Plan as follows: • Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure or necessary post-discharge follow-up. • Eligible Expenses for lodging for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to $150 per day. • Travel and lodging expenses are only available if the transplant recipient resides more than 50 miles from the Designated Facility. • If the patient is an Enrolled Dependent minor child, the transportation expenses of two companions will be covered and lodging expenses will be reimbursed up to the $150 per diem rate. There is a combined overall lifetime maximum Benefit of $10,000 per Covered Person for all transportation and lodging expenses incurred by the transplant recipient and companion(s) and reimbursed under this Plan in connection with all transplant procedures.	
42. 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 *Physician's*	$20 per visit

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
Office Services earlier in this section. To ensure prompt and accurate payment of your claim, notify the Claims Administrator within two business days after you receive care at an Urgent Care Center outside the service area.	
43. Vision Examinations and Vision Hardware The Plan pays Benefits for: • Vision screenings, which could be performed as part of an annual physical examination in a provider's office (vision screenings do not include refractive examinations to detect vision impairment). • One routine vision exam, including refraction, to detect vision impairment by a provider in the provider's office every plan year. The Plan pays up to $45 for an eye refraction exam. Lenses (per pair) are covered up to one per year as follows: • Single vision up to $28.80. • Bifocal, single up to $48.60. • Bifocal, double up to $88.20. • Trifocal up to $70.20. • Aphakic - glass up to $54. • Aphakic - plastic up to $126.	*Medical Health of the Eye:* *Primary Physician:* $15 per visit *Specialist Physician:* $25 per visit *Vision Hardware:* No Copayment; The Plan pays Benefits as described here.

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
• Aphakic - aspheric up to $162. Frames are covered up to once per year up to $45. All routine vision services and supplies available from any licensed vision provider, whether network or non-network. Contact lenses are covered up to once per year (in lieu of frames/lenses) as follows: • When medically necessary up to $201.60; or • For cosmetic reasons up to $50.40.	
44. Whole Blood and Blood Products The Plan pays Benefits for whole blood products, blood products, derivatives and components, artificial blood products, biological serum and the administration of the agent. Blood products shall include any product which is created from a component of blood such as, but not limited to plasma, packed red blood cells, platelets, albumin, Factor VIII, immunoglobulin and prolastin.	No Copayment
45. Wigs The Plan pays Benefits for wigs and other scalp hair prosthesis only when hair loss occurs due to chemotherapy or radiation for cancer. Benefits are limited to $350 per lifetime.	No Copayment

Section 2: What's Not Covered--Exclusions

This section contains information about:

- How headings are used in this section.
- Medical services that are not covered. We call these Exclusions. It's important for you to know what services and supplies are not covered under the Plan.

How We Use Headings in this Section

To help you find specific exclusions more easily, we use headings. The headings group services, treatments, items, or supplies that fall into a similar category. Actual exclusions appear underneath headings. A heading does not create, define, modify, limit or expand an exclusion. All exclusions in this section apply to you.

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 are true:

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

To continue reading, go to right column on this page.

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: What's Covered--Benefits) or through a Rider to the COC.

A. Alternative Treatments

1. Acupressure.
2. Aroma therapy.
3. Hypnotism.
4. Massage therapy, unless it is part of a comprehensive therapy program performed by a licensed chiropractor, physical therapist or Physician as a manual therapy technique.
5. Rolfing.
6. Other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health. This exclusion does not apply to Chiropractic Treatment, acupuncture, and osteopathic care for which Benefits are provided as described in (Section 1: What's Covered--Benefits).

B. Dental

1. Dental care except as described in (Section 1: What's Covered--Benefits) under the heading *Dental Services - Accident Only*.
2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include all of the following:
   - Extraction, restoration and replacement of teeth;
   - Medical or surgical treatments of dental conditions; or
   - Services to improve dental clinical outcomes.
3. Dental implants.
4. Dental braces.

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5. Dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia except as described in (Section 1: What's Covered--Benefits) under the heading *Dental Services - Accident Only*. The only exceptions to this are for any of the following:
   - Transplant preparation;
   - Initiation of immunosuppressives; or
   - The direct treatment of acute traumatic Injury, cancer or cleft palate.
6. Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a Congenital Anomaly.

C. Devices, Appliances and Prosthetics

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Orthotic appliances and devices, except when all of the following are met:
   - prescribed by a Physician for a medical purpose; and
   - custom manufactured or custom fitted to an individual Covered Person.

   Examples of excluded orthotic appliances and devices include but are not limited to, cranial bands or any braces that can be obtained without a Physician's order. This exclusion does not include diabetic footwear which may be covered for a Covered Person with diabetic foot disease or for shoe orthotics as described under *Durable Medical Equipment* in (Section 1: What's Covered--Benefits).
3. The following items are excluded, even if prescribed by a Physician:
   - Blood pressure cuff/monitor;

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   - Enuresis alarm;
   - Home coagulation testing equipment;
   - Non-wearable external defibrillator;
   - Trusses; or
   - Ultrasonic nebulizers.
4. The repair and replacement of prosthetic devices when damaged due to misuse, malicious breakage or gross neglect.
5. The replacement of lost or stolen prosthetic devices.
6. Devices and computers to assist in communication and speech except for speech aid prosthetics and tracheo-esophageal voice prosthetics.
7. Oral appliances for snoring.

D. Drugs

1. Prescription drugs for outpatient use that are filled by a prescription order or refill.
2. Self-injectable medications (This exclusion does not apply to medications which, due to their characteristics, as determined by the Claims Administrator, must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting).
3. Growth hormone therapy.
4. Non-injectable medications given in a Physician's office except as required in an emergency and consumed in the Physician's office.
5. Over the counter drugs and treatments.

To continue reading, go to left column on next page.

E. Experimental, Investigational or Unproven Services

Experimental, Investigational and Unproven Services are excluded. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.

This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in (Section 1: What's Covered--Benefits).

F. Foot Care

1. Routine foot care (including the cutting or removal of corns and calluses), except when needed for severe systemic disease or preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under *Diabetes Services* in (Section 1: What's Covered--Benefits).
2 Nail trimming, cutting, or debriding.
3. Hygienic and preventive maintenance foot care. Examples include the following:
   - Cleaning and soaking the feet.
   - Applying skin creams in order to maintain skin tone.
   - Other services that are performed when there is not a localized illness, Injury or symptom involving the foot.
4. Treatment of flat feet.
5. Treatment of subluxation of the foot.

To continue reading, go to right column on this page.

6. Shoe orthotics in excess of the limit described under *Durable Medical Equipment (DME)* in (Section 1: What's Covered--Benefits).

G. Medical Supplies and Equipment

1. Prescribed or non-prescribed medical and disposable supplies. Examples of supplies that are not covered include, but are not limited to:
   - Elastic stockings.
   - Ace bandages.

   This exclusion does not apply to:
   - Compression stockings.
   - Surgical dressings and burn garments for wound care.
   - Urinary catheters and urological supplies.
   - Ostomy bags and related supplies for which Benefits are provided as described under *Ostomy Supplies* in (Section 1: What's Covered--Benefits).
   - Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Diabetes Services* in (Section 1: What's Covered--Benefits).
   - Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in (Section 1: What's Covered--Benefits).
2. Tubings, nasal cannulas, connectors and masks except when used with Durable Medical Equipment.
3. The repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect.
4. The replacement of lost or stolen Durable Medical Equipment.

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5. Deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover or other items that are not specifically identified in (Section 1: What's Covered--Benefits).

H. Mental Health/Substance Use Disorder

Exclusions listed directly below apply to services described under Mental Health Services, Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders and/or Substance Use Disorder Services in Section 1, What's Covered--Benefits.

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
2. Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance use disorders that in the reasonable judgment of the Mental Health/Substance Use Disorder Administrator, are any of the following:
   - not consistent with generally accepted standards of medical practice for the treatment of such conditions;
   - not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental;
   - not consistent with the Mental Health/Substance Use Disorder Administrator's level of care guidelines or best practices as modified from time to time; or
   - not clinically appropriate for the patient's Mental Illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks.

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3. Mental Health Services as treatments for V-code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
4. Mental Health Services as treatment for a primary diagnosis of insomnia other sleep disorders, sexual dysfunction disorders, feeding disorders (i.e. anorexia or bulimia), neurological disorders and other disorders with a known physical basis;
5. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders (i.e. OCD), personality disorders and paraphilias (sexual behavior that is considered deviant or abnormal);
6. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning;
7. Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*;
8. Learning, motor skills and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
9. Mental retardation as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
10. Intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorders; and
11. Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.

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I. Nutrition

1. Megavitamin and nutrition based therapy.
2. Nutritional counseling for either individuals or groups, except as identified under *Diabetes Services*, and except as defined under *Nutritional Counseling* in (Section 1: What's Covered--Benefits).
3. Food of any kind, except as described under *Amino Acid-Based Elemental Formula* and *Medical Foods and Tube Feeding Supplies* in (Section 1: What's Covered--Benefits). Foods that are not covered include:
   - Enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk, unless they are the only source of nutrition or unless they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU) – infant formula available over the counter is always excluded.
   - Foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes.
   - Oral vitamins and minerals.
   - Meals you can order from a menu, for an additional charge, during an Inpatient Stay.
   - Other dietary and electrolyte supplements.
4. Health education classes unless offered by the Claims Administrator or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

J. Personal Care, Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/barber service.
4. Guest service.

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5. Supplies, equipment and similar incidentals for personal comfort. Examples include:
   - Air conditioners.
   - Air purifiers and filters.
   - Batteries and battery chargers.
   - Breast pumps. This exclusion does not apply to breast pumps for which Benefits are identified under Preventive Care Services in Section 1;
   - Car seats.
   - Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners.
   - Dehumidifiers and humidifiers.
   - Electric scooters.
   - Ergonomically correct chairs.
   - Exercise equipment and treadmills.
   - Home modifications to accommodate a health need (including, but not limited to, ramps, swimming pools, elevators, handrails, and stair glides).
   - Hot tubs, Jacuzzis, saunas and whirlpools.
   - Medical alert systems.
   - Music devices.
   - Non-Hospital beds, comfort beds, motorized beds and mattresses.
   - Personal computers.
   - Pillows.
   - Power-operated vehicles.
   - Radios.

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— Strollers.

— Safety equipment.

— Vehicle modifications such as van lifts.

— Video players.

K. Physical Appearance

1. Cosmetic Procedures. See the definition in (Section 10: Glossary of Defined Terms). Examples include:
   — Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
   — Pharmacological regimens.
   — Nutritional procedures or treatments.
   — Tattoo or scar removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   — Hair removal or replacement by any means.
   — Treatments for skin wrinkles or any treatment to improve the appearance of the skin.
   — Treatment for spider veins.
   — Skin abrasion procedures performed as a treatment for acne.
   — Treatments for hair loss.
   — Varicose vein treatment of the lower extremities, when it is considered cosmetic.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure.
   Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in (Section 1: What's Covered--Benefits).
3. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.
4. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
5. Wigs regardless of the reason for the hair loss except for hair loss due to chemotherapy or radiation for cancer, in which case the Plan pays up to a maximum of $350 per Covered Person per lifetime.

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L. Procedures and Treatments

1. Biofeedback.
2. Medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea (a sleep disorder in which a person regularly stops breathing for 10 seconds or longer).
3. Speech therapy to treat stuttering, stammering, or other articulation disorders.
4. Speech therapy, except when required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, a Congenital Anomaly or autism spectrum disorders as identified under *Rehabilitation Services – Outpatient Therapy* in (Section 1: What's Covered--Benefits).
5. A procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy.
6. Excision or elimination of hanging skin on any part of the body (examples include plastic surgery procedures called

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abdominoplasty or abdominal panniculectomy and brachioplasty).

7. Psychosurgery (lobotomy).
8. Treatment of tobacco dependency.
9. Chelation therapy, except to treat heavy metal poisoning.
10. Chiropractic Treatment to treat a condition unrelated to spinal manipulation and ancillary physiologic treatment rendered to restore/improve motion, reduce pain and improve function, alignment of the vertebral column, such as asthma or allergies.
11. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.
12. Sex transformation operations.
13. The following treatments for obesity:
    - Non-surgical treatment, even if for morbid obesity; and
    - surgical treatment of obesity unless there is a diagnosis of morbid obesity as described under *Obesity Surgery* in (Section 1: What's Covered--Benefits).
14. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), when the services are considered dental in nature, including oral appliances, surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; dental restorations, unless as described under *Temporomandibular Joint (TMJ)* in (Section 1: What's Covered--Benefits).
15. Diagnosis or treatment of the jawbones, including orthognathic surgery (procedure to correct underbite or overbite) and jaw alignment, except as treatment of obstructive sleep apnea.

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16. Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury, dislocation, tumor or cancer.

M. Providers

Services:

1. Performed by a provider who is a family member by birth or marriage, including your Spouse, brother, sister, parent or child.
2. A provider may perform on himself or herself.
3. Performed by a provider with your same legal residence.
4. Ordered or delivered by a Christian Science practitioner.
5. Performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license.
6. Foreign language and sign language interpreters.
7. Provided at a diagnostic facility (Hospital or free-standing) without a written order from a provider.
8. Which are self-directed to a free-standing or Hospital-based diagnostic facility.
9. Ordered by a provider affiliated with a diagnostic facility (Hospital or free-standing), when that provider is not actively involved in your medical care:
    - Prior to ordering the service; or
    - After the service is received.

    This exclusion does not apply to mammography testing.

N. Reproduction

1. Surrogate parenting, donor eggs, donor sperm and host uterus.
2. The reversal of voluntary sterilization in excess of one per Covered Person per lifetime.

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3. Health services and associated expenses for elective abortion and fetal reduction surgery, except when occurring during the first trimester.
4. Health services associated with the use of non-surgical or drug-induced Pregnancy termination after the first trimester.
5. The following infertility treatment-related services:
   - gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT) unless related to IVF;
   - cryo-preservation and other forms of preservation of reproductive materials;
   - long-term storage of reproductive materials such as sperm, eggs, embryos, ovarian tissue, and testicular tissue;
   - sex selection services;
   - donor services; and
   - the cost of any prescription medication treatment for in vitro fertilization, gamete intrafallopian transfer (GIFT) procedures and zygote intrafallopian transfer (ZIFT) procedures, except as described under *Infertility Services* in (Section 1: What's Covered--Benefits).
6. Services provided by a doula (labor aide).
7. Parenting, pre-natal or birthing classes.
8. Artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes.

O. Services Provided under Another Plan

Services for which coverage is available:

1. Under another plan, except for Eligible Expenses payable as described in (Section 7: Coordination of Benefits).

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2. Under workers' compensation, no-fault automobile coverage or similar legislation if you could elect it, or could have it elected for you.
3. While on active military duty.
4. For treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably accessible.

P. Transplants

1. Health services for organ, multiple organ and tissue transplants, except as described in (Section 1: What's Covered--Benefits) unless the Claims Administrator determines the transplant to be appropriate according to the Claims Administrator's transplant guidelines.
2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's Benefits under the Plan).
3. Health services for transplants involving mechanical or animal organs.
4. Any solid organ transplant that is performed as a treatment for cancer.

Q. Travel

1. Health services provided in a foreign country, unless required as Emergency Health Services.
2. Travel or transportation expenses, even if ordered by a Physician, except as identified under *Travel and Lodging* in (Section 1: What's Covered--Benefits). Additional travel expenses related to Covered Health Services received from a

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Designated Facility or Designated Physician may be reimbursed at the Plan's discretion.

R. Types of Care

1. Custodial Care as defined in (Section 10: Glossary of Defined Terms).
2. Domiciliary Care, as defined in (Section 10: Glossary of Defined Terms).
3. Multi-disciplinary pain management programs provided on an inpatient basis.
4. Private duty nursing received on an inpatient basis.
5. Respite care.
6. Rest cures.
7. Services of personal care attendants.
8. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

S. Vision and Hearing

1. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants).
2. Purchase cost and associated fitting charges for eyeglasses or contact lenses, except as described under *Vision Examinations and Vision Examinations and Vision Hardware* in (Section 1: What's Covered--Benefits).
3. Eye exercise therapy.
4. Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery.

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T. All Other Exclusions

1. Autopsies and other coroner services and transportation services for a corpse.
2. Charges for:
   - Missed appointments.
   - Room or facility reservations.
   - Completion of claim forms.
   - Record processing.
3. Charges prohibited by federal anti-kickback or self-referral statutes;
4. Diagnostic tests that are:
   - Delivered in other than a Physician's office or health care facility.
   - Self-administered home diagnostic tests, including but not limited to HIV and Pregnancy tests.
5. Expenses for health services and supplies:
   - That do not meet the definition of a Covered Health Service in (Section 10: Glossary of Defined Terms
   - That are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country.
   - That are received after the date your coverage under this Plan ends, including health services for medical conditions which began before the date your coverage under the Plan ends.
   - For which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Benefit Plan.

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- That exceed Eligible Expenses or any specified limitation in this COC.
- For which a non-Network provider waives the Copay amounts.

6. Long term (more than 30 days) storage of blood, umbilical cord or other material. Examples include cryopreservation of tissue, blood and blood products; and
7. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:
   - Required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption; or as a result of incarceration.
   - Conducted for purposes of medical research.
   - Related to judicial or administrative proceedings or orders.
   - Required to obtain or maintain a license of any type.

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Section 3: Obtaining Benefits

This section includes information about:

- Obtaining Benefits.
- Emergency Health Services.

Benefits

Benefits are payable for Covered Health Services which are any of the following:

- Provided by or under the direction of your Primary Physician in the Physician's office or at a Network facility.
- Emergency Health Services.
- Urgent Care Center services received outside the service area.

Benefits are not payable for Covered Health Services that are provided by non-Network providers.

Please note that Mental Health Services, Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorder and Substance Use Disorder Services must be authorized by the Mental Health/Substance Use Disorder Designee. Please see (Section 1: What's Covered--Benefits) under the headings for *Mental Health Services*, *Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorder* and *Substance Use Disorder Services*.

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Selecting a Primary Physician

You must select or we will assign a Primary Physician. Your Primary Physician will be responsible for coordinating all Covered Health Services and for ensuring continuity of care.

If you are the custodial parent of an Enrolled Dependent child, you must select a Primary Physician for that child.

You may change your Primary Physician by contacting the Claims Administrator at the telephone number shown on your ID card.

Provider Network

The Claims Administrator arranges for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees or employees of the Claims Administrator. It is your responsibility to select your provider.

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

You will be given a directory of Network providers. However, before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling the Claims Administrator.

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.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract to

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provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some products. Refer to your provider directory or contact the Claims Administrator for assistance.

Care Coordination℠

Your Primary Physician and other Network providers are required to notify the Claims Administrator regarding certain proposed or scheduled health services. When your Primary Physician or other Network provider notifies the Claims Administrator, they will work together to implement the Care Coordination℠ process and to provide you with information about additional services that are available to you, such as disease management programs, health education, pre-admission counseling and patient advocacy.

If you receive certain Covered Health Services from a Network provider, you must notify the Claims Administrator. The Covered Health Services for which notification is required is shown in (Section 1: What's Covered--Benefits). When you notify the Claims Administrator, you will be provided with the Care Coordination services described above.

Referral Health Services

All Covered Health Services must be provided by or coordinated through your Primary Physician. The only exception to this is Emergency Health Services. If your Primary Physician is not able to provide a Covered Health Service, he or she will refer you to a Network specialist or other Network provider.

In some cases, Benefits are provided for certain Covered Health Services that are obtained directly from a Network provider without a referral by your Primary Physician. Your Primary Physician will identify for you any Covered Health Service for which a referral is not required. Please note, however, that Benefits are not available

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for Covered Health Services that require a direct referral, unless you have obtained the appropriate referral from your Primary Physician.

Designated Facilities and Other Providers

If you have a medical condition that the Claims Administrator believes needs special services, they may direct you to a Designated Facility or other provider chosen by them. If you require certain complex Covered Health Services for which expertise is limited, the Claims Administrator may direct you to a non-Network facility or provider.

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

You or your Primary Physician or other Network Physician must notify the Claims Administrator of special service needs (including, but not limited to, transplants or cancer treatment) that might warrant referral to a Designated Facility or non-Network facility or provider. If you do not notify the Claims Administrator 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, Benefits will not be paid.

Benefits for Health Services from Non-Network Providers

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from non-Network providers. In this situation, your Primary Physician will notify the Claims Administrator, and they will work with you and your Primary Physician to coordinate care through a non-Network provider.

To continue reading, go to left column on next page.

Emergency Health Services

We provide Benefits for Emergency Health Services when required for stabilization and initiation of treatment as provided by or under the direction of a Physician.

We provide Benefits for Emergency Health Services even if you do not have a referral from your Primary Physician. Whenever possible, you should contact your Primary Physician before receiving Emergency Health Services, and then seek care from the Network provider he or she designates.

Benefits are paid for Emergency Health Services, even if the services are provided by a non-Network provider.

If you are confined in a non-Network Hospital after you receive Emergency Health Services, the Claims Administrator must be notified within one business day or on the same day of admission if reasonably possible. The Claims Administrator 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 the date the Claims Administrator decides a transfer is medically appropriate, Benefits will not be available.

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Section 4: When Coverage Begins

This section includes information about:

- How to enroll.
- If you are hospitalized when this coverage begins.
- Who is eligible for coverage.
- When to enroll.
- When coverage begins.

How to Enroll

To enroll, the Eligible Person must complete an enrollment form. The Plan Administrator or its designee will give the necessary forms to you, along with instructions about submitting your enrollment form and any required contribution for coverage. 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 Inpatient Rehabilitation Facility on the day your coverage begins, we will pay Benefits for Covered Health Services related to that

To continue reading, go to right column on this page.

Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Plan.

You should notify the Claims Administrator within 48 hours of the day your coverage begins, or as soon as is reasonably possible. Benefits are available only if you receive Covered Health Services at a Network facility under the direction of your Primary Physician.

If You Are Eligible for Medicare

Your Benefits under the Plan may be reduced if you are eligible for Medicare but do not enroll in and maintain coverage under both Medicare Part A and Part B.

Your Benefits under the Plan may also be reduced if you are enrolled in a Medicare Advantage (Medicare Part C) plan but fail to follow the rules of that plan. Please see *Medicare Eligibility* in (Section 9: General Legal Provisions) for more information about how Medicare may affect your Benefits.

Special Note Regarding Medicare

If you are enrolled in Medicare and Medicare pays benefits before the Plan, Copayments are waived.

Since Medicare pays benefits first, the Plan will pay Benefits second as described in (Section 7: Coordination of Benefits).

To continue reading, go to left column on next page.

Who is Eligible for Coverage

Who	Description	Who Determines Eligibility
Eligible Person	Eligible Person usually refers to an employee of ours who meets the eligibility rules. When an Eligible Person actually enrolls, we refer to that person as a Participant. For a complete definition of Eligible Person and Participant, see (Section 10: Glossary of Defined Terms). If both spouses are Eligible Persons under the Plan, each may enroll as a Participant or be covered as an Enrolled Dependent of the other, but not both.	We determine who is eligible to enroll under the Plan.
Dependent	Dependent generally refers to the Participant'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 10: Glossary of Defined Terms). Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Plan. If both parents of a Dependent child are enrolled as a Participant, only one parent may enroll the child as a Dependent. Except as we have described in (Section 4: When Coverage Begins), Dependents may not enroll.	We determine who qualifies as a Dependent.

When to Enroll and When Coverage Begins

When to Enroll	Who Can Enroll	Begin Date
Initial Enrollment Period The Initial Enrollment Period is the first period of time when Eligible Persons can enroll.	Eligible Persons may enroll themselves and their Dependents.	Coverage begins on the date identified by the Plan Administrator, if your Agency Benefit Coordinator and Employee Benefits Division receives the completed enrollment form and any required contribution for coverage within 60 days of the date the Eligible Person becomes eligible to enroll.
Open Enrollment Period	Eligible Persons may enroll themselves and their Dependents.	The Plan Administrator determines the Open Enrollment Period. Coverage begins on the date identified by the Plan Administrator if your Agency Benefit Coordinator and Employee Benefits Division receives the completed enrollment form and any required contribution within the time period allotted by the Plan Administrator.
New Eligible Persons	New Eligible Persons may enroll themselves and their Dependents.	Once your Agency Benefit Coordinator and the Employee Benefits Division receives your properly completed enrollment, coverage will begin either the 1st or 16th of the month, based on the pay period in which the first deduction is taken. Coverage for your Dependents will start on the date your coverage begins, provided you have enrolled them in a timely manner. For newly retired employees, coverage begins the first of the month. Coverage for a Spouse or Dependent stepchild that you acquire via marriage becomes effective

When to Enroll	Who Can Enroll	Begin Date
		the first or 16th of the month based on the pay period in which the first deduction is taken, provided you notify your Agency Benefit Coordinator within 60 days of your marriage. Coverage for Dependent children acquired through birth, adoption, or placement for adoption is effective the date of the family status change only if you have requested a retroactive adjustment, otherwise either the first or 16th of the month based on the pay period in which the first deduction is taken provided you notify your Agency Benefit Coordinator within 60 days of the birth, adoption, or placement.
Adding New Dependents	Participants may enroll Dependents who join their family because of any of the following qualifying events: • Birth. • Legal adoption. • Placement for adoption. • Marriage. • Legal guardianship. • Court or administrative order. • Registering a Domestic Partner.	Coverage for a Dependent will become effective the 1st or 16th of the month based on the pay period in which the first deduction is taken, provided you notify your Agency Benefit Coordinator within 60 days of the qualifying event. A retroactive adjustment may be requested to ensure coverage is effective back to the qualifying event.

Special Enrollment Period

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

An Eligible Person and/or Dependent does not need to elect COBRA continuation coverage to preserve special enrollment rights. Special enrollment is available to an Eligible Person and/or Dependent even if COBRA is 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 or divorce.
- Dissolution of a Domestic Partnership.

A special enrollment period 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 Plan, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under Medicaid or State Children's Health Insurance Program (SCHIP) (you must notify your Agency Benefit Coordinator or the Employee Benefits Division within 60 days of determination of subsidy eligibility);
- 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

Event Takes Place (for example, a birth, marriage or determination of eligibility for state subsidy). Unless otherwise noted under the "Who Can Enroll" column, coverage will begin either the 1st or 16th of the month, based on the pay period in which the first deduction is taken if your Agency Benefit Coordinator or the Employee Benefits Division receives the completed enrollment form and any required contribution within 60 days of the event.

Missed Initial Enrollment Period or Open Enrollment Period. Unless otherwise noted under the "Who Can Enroll" column, coverage begins on the day immediately following the day coverage under the prior plan ends if your Agency Benefit Coordinator or the Employee Benefits Division receives the completed enrollment form and any required contribution within 60 days of the date coverage under the prior plan ended.

When to Enroll	Who Can Enroll	Begin Date
	• Coverage under the prior plan ended because of any of the following: — Loss of eligibility (including, without limitation, legal separation, divorce or death). — 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. — The Plan no longer offers benefits to a class of individuals that include the Eligible Person and/or Dependent. — Termination of your or your Dependent's Medicaid or State Children's Health Insurance Program (SCHIP) coverage as a result of loss of eligibility (you must notify your Agency Benefit Coordinator or the Employee Benefits Division within 60 days of termination).	

Section 5: How to File a Claim

This section provides you with information about:

- How and when to file a claim.
- If you receive Covered Health Services from a Network provider, you do not have to file a claim. We pay these providers directly.
- If you receive Covered Health Services from a non-Network provider, you are responsible for filing 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 the Claims Administrator. However, you are responsible for paying Copayments to a Network provider at the time of service, or when you receive a bill from the provider.

Filing a Claim for Benefits

When you receive Covered Health Services from a non-Network provider as a result of an Emergency or if we refer you to a non-Network provider, you are responsible for requesting payment from us through the Claims Administrator. You must file the claim in a

To continue reading, go to right column on this page.

format that contains all of the information required, as described below.

You must submit a request for payment of Benefits to the Claims Administrator within one year of the date of service or Benefits for that health service will be denied. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Required Information

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

A. Participant's name and address.
B. The patient's name, age and relationship to the Participant.
C. The member number stated on your ID card.
D. An itemized bill from your provider that includes the following:
   — Patient diagnosis
   — Date of service
   — Procedure code(s) and description of service(s) rendered
   — Provider of service (Name, Address and Tax Identification Number)
E. The date the Injury or Sickness began.
F. 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).

Payment of Benefits

Through the Claims Administrator, we will make a benefit determination as set forth below.

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You may not assign your Benefits under the Plan to a non-Network provider without our consent. The Claims Administrator may, however, in their discretion, pay a non-Network provider directly for services rendered to you.

The Claims Administrator will notify you if additional information is needed to process the claim. The Claims Administrator may request a one time extension not longer than 15 days and will pend your claim until all information is received. Once you are notified of the extension or missing information, you then have at least 45 days to provide this information.

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Section 6: Questions, Complaints and Appeals

This section provides you with information to help you with the following:

- You have a question or concern about Covered Health Services or your Benefits.
- You have a complaint.
- How to handle an appeal that requires immediate action.
- You are notified that a claim has been denied because it has been determined that a service or supply is excluded under the Plan and you wish to appeal such determination.

What to Do First

If your question or concern is about a benefit determination, you may informally contact Customer Service before requesting a formal appeal. If the Customer Service representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination you may appeal it as described below, without first informally contacting Customer Service. If you first informally contact Customer Service and later wish to request a formal appeal in writing, you should contact Customer Service and request an

To continue reading, go to right column on this page.

appeal. If you request a formal appeal, a Customer Service representative will provide you with the appropriate address of the Claims Administrator.

If you are appealing an urgent care claim denial, please refer to the "Urgent Appeals that Require Immediate Action" section below and contact Customer Service immediately. The Customer Service telephone number is shown on your ID card. Customer Service representatives are available to take your call.

How to Appeal a Claim Decision

If you wish to appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefit determination. You do not need to submit Urgent Care appeals in writing.

Your request should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your appeal request must be submitted to the Claims Administrator within 180 days after you receive the claim denial.

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Requests for Review of Denied Claims, Appeals, and Notice of Complaints:

Name and Address for Submitting Requests:

UnitedHealthcare - Appeals
P.O. Box 30432
Salt Lake City, UT 84130-0432

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The Claims Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon your request and free of charge, you have the right to reasonable access to (including copies of) all documents, records, and other information relevant to your claim for Benefits.

Appeals Determinations

Pre-Service Requests for Benefits and Post-Service Claim Appeals

You will be provided written or electronic notification of decision on your appeal as follows:

For appeals of pre-service requests for Benefits, the appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for appeal of a denied request for Benefits.

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For appeals of post-service claims, the appeal will be conducted and you will be notified by the Claims Administrator of the decision within 60 days from receipt of a request for appeal of a denied claim.

For procedures associated with urgent requests for Benefits, see "Urgent Appeals that Require Immediate Action" below.

The Claims Administrator has the sole and absolute discretionary authority to interpret and administer the Plan, and these decisions are conclusive and binding on all persons affected thereby.

Please note that a decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your Physician.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations:

> The appeal does not need to be submitted in writing. You or your Physician should call the Claims Administrator as soon as possible. The Claims Administrator will provide you with a written or electronic determination within 24 hours following receipt by the Claims Administrator of your request for review of the determination taking into account the seriousness of your condition.

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For urgent requests for Benefits appeals, we have delegated to the Claims Administrator the sole and absolute discretionary authority to interpret and administer the Plan. These decisions are conclusive and binding on all persons affected thereby.

External Review Rights

If, after exhausting your internal appeals through the Claims Administrator, you are not satisfied with the final internal appeals determination, you may have a right to have the decision reviewed by the Maryland Insurance Administration (MIA) if the decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested by submitting a request. For such cases, please submit your request, along with any additional information you want considered, within 120 days of the date you receive the letter of final internal appeals determination to:

Maryland Insurance Administration
Appeals and Grievance Unit
200 St. Paul Place, Suite 2700
Baltimore, MD 21202
Phone: (410) 468-2000
Toll-free: (800) 492-6116
TTY: (800)-735-2258
Fax: (410) 468-2270

If your claim is denied because the service was not a covered service it may not be eligible for an independent, external review. If you still disagree with the denial, however, you may contact the State of Maryland Employee Benefits Division at the following:

Employee Benefits Division
Attn: Adverse Determinations
301 West Preston Street, Room 510

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Baltimore, MD 21201
Telephone: (410) 767-4775
Toll-free: 1-800-307-8283
Facsimile: (401) 333-7104

All requests for final appeals must be made within 120 days of the date you receive the final internal appeals determination. You, your treating Physician or an authorized designated representative may request the external review.

If there is any information or evidence you or your Physician wish to submit in support of the request that was not previously provided, you may include this information with the request for the final appeal. A decision will be made within applicable timeframes, and the decision will be in writing. If additional information is necessary to make a decision, this time period may be extended. The final appeal review process will be expedited if you meet the criteria for an expedited external review as defined by applicable law.

If the external review decision is to approve payment or referral, the Plan will accept the decision and provide Benefits for such service or procedure in accordance with the terms and conditions of the Plan. If the external review decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the service or procedure.

You may contact the Maryland Insurance Administration at (800) 492-6116 for more information regarding your final appeal rights.

Limitation of Action

You cannot bring any legal action against the State of Maryland or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against the State

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of Maryland or the Claims Administrator, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against the State of Maryland or the Claims Administrator.

You cannot bring any legal action against the State of Maryland or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against the State of Maryland or the Claims Administrator you must do so within three years of the date you are notified of our final decision on your appeal or you lose any rights to bring such an action against the State of Maryland or the Claims Administrator.

Availability of Consumer Assistance/Ombudsman Services

In addition, there may be other resources available to help you understand the appeals process. For questions about your rights or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

THERE IS HELP AVAILABLE TO YOU IF YOU WISH TO DISPUTE THE DECISION OF THE PLAN ABOUT PAYMENT FOR HEALTH CARE SERVICES.

You or your authorized representative may contact the Health Advocacy Unit of Maryland's Consumer Protection Division:

Health Education and Advocacy Unit
Division of Consumer Protection
Office of the Attorney General
200 St. Paul Place
Baltimore, MD 21202-2272

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Phone: (410) 528-1840 or toll-free (877) 261-8807
Fax: (410) 576-6571
E-mail: heau@oag.state.md.us

The Health Advocacy Unit can help you and your health care provider file an appeal under the Claims Administrator's appeal process. That unit can also attempt to mediate a resolution to your dispute. The Health Advocacy Unit is not available to represent or accompany you during any proceeding of the internal grievance process.

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Section 7: Coordination of Benefits

Coordination of Benefits (COB) applies to you if you are covered by more than one health benefits plan, including any one of the following:

- another employer sponsored health benefits plan;
- a medical component of a group long-term care plan, such as skilled nursing care;
- no-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy;
- medical payment benefits under any premises liability or other types of liability coverage; or
- Medicare or other governmental health benefit.

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the primary plan.

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Determining Which Plan is Primary

If you are covered by two or more plans, the benefit payment follows the rules below in this order:

- this Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy;
- when you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first;
- a plan that covers a person as an employee pays benefits before a plan that covers the person as a dependent;
- if you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first;
- your dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:
  - the parents are married or living together whether or not they have ever been married and not legally separated; or
  - a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage;
- if two or more plans cover a dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:
  - the parent with custody of the child; then
  - the Spouse of the parent with custody of the child; then
  - the parent not having custody of the child; then

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— the Spouse of the parent not having custody of the child;

- plans for active employees pay before plans covering laid-off or retired employees;
- the plan that has covered the individual claimant the longest will pay first. Only expenses normally paid by the Plan will be paid under COB; and
- finally, if none of the above rules determines which plan is primary or secondary, 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.

When This Plan is Secondary to any Plan other than Medicare

If this Plan is secondary to any plan other than Medicare, it determines the amount it will pay for a Covered Health Service by following the steps below.

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

You will be responsible for any Coinsurance or Deductible payments as part of the COB payment. Copays will be waived.

When This Plan is Secondary to Medicare

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

To continue reading, go to right column on this page.

- When Benefit for covered services are paid by Medicare primary, UnitedHealthcare will not duplicate those payments.
- if this Plan would have paid more than the primary plan paid, the Plan will pay the difference less any applicable Deductible and Coinsurance requirements of the Plan.

You will be responsible for any Coinsurance or Deductible payments as part of the COB payment. Copays will be waived.

Determining the Allowable Expense If This Plan is Secondary

If this Plan is secondary and the expense meets the definition of a Covered Health Service under this Plan, the allowable expense is the primary plan's Network rate. If the primary plan bases its reimbursement on reasonable and customary charges, the allowable expense is the primary plan's reasonable and customary charge. If both the primary plan and this Plan do not have a contracted rate, the allowable expense will be the greater of the two plans' reasonable and customary charges.

When the provider is a Network provider for both the primary plan and this Plan, the allowable expense is the primary plan's network rate. When the provider is a network provider for the primary plan and a non-Network provider for this Plan, the allowable expense is the primary plan's network rate. When the provider is a non-Network provider for the primary plan and a Network provider for this Plan, the allowable expense is the reasonable and customary charges allowed by the primary plan. When the provider is a non-Network provider for both the primary plan and this Plan, the allowable expense is the greater of the two Plans' reasonable and customary charges.

To continue reading, go to left column on next page.

What is an allowable expense?
For purposes of COB, an allowable expense is a health care expense that meets the definition of a Covered Health Service under this Plan.

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

To the extent permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- employees with active current employment status age 65 or older and their Spouses age 65 or older; and
- individuals with end-stage renal disease, for a limited period of time.

Determining the Allowable Expense When This Plan is Secondary

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts Medicare. If the provider does not accept Medicare, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the total allowable expense.

If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, Benefits payable under this Plan will be reduced by the amount that would have been paid if you had been enrolled in Medicare.

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Medicare Cross-Over Program

The Plan offers a Medicare Cross-over Program for Medicare Part B and Durable Medical Equipment (DME) claims. If you enroll for this program, you no longer have to file a separate claim with the Plan to receive secondary benefits for these expenses.

Once the Medicare Part B and DME carrier(s) have reimbursed your health care provider, the Medicare carrier will electronically submit the necessary information to the Claims Administrator to process the balance of your claim under the provisions of this Plan.

To participate in the Medicare Cross-over Program, you must complete a special form authorizing this service and submit it to the Claims Administrator. Your Spouse also can enroll for this program, as long as he or she is eligible for Medicare and this Plan is your only secondary medical coverage.

You can verify that the automated cross-over is in place when your copy of the explanation of Medicare benefits (EOMB) states your claim has been forwarded to your secondary carrier. Until this message appears, you must continue to file secondary claims with the Claims Administrator.

This cross-over process does not apply to expenses under Part A of Medicare (hospital expenses) or expenses that Medicare does not cover. You must continue to file claims for these expenses.

For information about enrollment or if you have questions about the program, call the telephone number listed on the back of your ID card.

To continue reading, go to left column on next page.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. The Plan Administrator may get the facts needed 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.

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

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that UnitedHealthcare should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Group may recover the amount in the form of salary, wages, or benefits payable under any Group-sponsored benefit plans, including this Plan. The Group also reserves the right to recover any overpayment by legal action or offset payments on future Eligible Expenses.

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If the Plan overpays a health care provider, UnitedHealthcare reserves the right to recover the excess amount, by legal action if necessary.

Refund of Overpayments

If the employer pays for 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 the employer if:

- 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;
- all or some of the payment the employer made exceeded the Benefits under the Plan; or
- all or some of the payment was made in error.

The refund equals the amount the Employer paid in excess of the amount that should have been paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help the employer get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, the employer may reduce the amount of any future Benefits for the Covered Person that are payable under the Plan. The reductions will equal the amount of the required refund. The employer may have other rights in addition to the right to reduce future Benefits.

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Section 8: When Coverage Ends

This section provides you with information about all of the following:

- Events that cause coverage to end.
- The date your coverage ends.
- Continuation of coverage under federal law (COBRA).
- Conversion

General Information about When Coverage Ends

We may discontinue this benefit Plan and/or all similar benefit plans at any time.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, the State of Maryland will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, Benefits are not provided for health services that you receive after coverage ended, even if the underlying medical condition occurred before your coverage ended.

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An Enrolled Dependent's coverage ends on the date the Participant's coverage ends.

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Events Ending Your Coverage

Coverage ends on the earliest of the dates specified in the following table:

Ending Event	What Happens
The Entire Plan Ends	Your coverage ends on the date the Plan ends. We are responsible for notifying you that your coverage has ended.
You Are No Longer Eligible	Your coverage under the Plan will end on the earliest of: • The 15th of the month if your employment with the Group ends on or before the 15th of the month; • Last day of the month your employment with the Group ends if your employment with the Group ends on or after the 16th of the month; • The date the Plan ends; or • The end of the pay period covered by your last deduction or payment. Coverage for your Enrolled Dependents will end on the earliest of: • The date your coverage ends; • At the end of the pay period covered by your last deduction or payment; • The 15th of the month or the last day of the month based on when your Dependent no longer qualifies as a Dependent under this Plan; or • The end of the month in which your Enrolled Dependent turns age 26. Please refer to (Section 10: Glossary of Defined Terms) for a more complete definition of the terms "Eligible Person", "Participant", "Dependent" and "Enrolled Dependent".

Ending Event	What Happens
The Claims Administrator Receives Notice to End Coverage	Your coverage ends on the date the Claims Administrator receives written notice from us instructing the Claims Administrator to end your coverage, or the date requested in the notice, if later.
Participant Retires or Is Pensioned	Your coverage ends the date the Participant is retired or pensioned under the Plan. We are responsible for providing written notice to the Claims Administrator to end your coverage. This provision applies unless we designate a specific coverage classification for retired or pensioned persons, and only if the Participant continues to meet any applicable eligibility requirements. We can provide you with specific information about what coverage is available for retirees.

Other Events Ending Your Coverage

When any of the following happen, we will provide written notice to the Participant that coverage has ended on the date the Plan Administrator identifies in the notice:

Ending Event	What Happens
Fraud, Misrepresentation or False Information	The Participant commits an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include, but are not limited to, false information relating to another person's eligibility or status as a Dependent.
Threatening Behavior	You commit an act of physical or verbal abuse that imposes a threat to our staff, the Claims Administrator's staff, a provider, or other Covered Persons.
Failure to Pay	Your coverage ends on the date identified by the Plan Sponsor if you fail to pay a required contribution.

Coverage for a Handicapped Child

Coverage for an unmarried Enrolled Dependent child who is not able to be self-supporting because of mental retardation or a physical handicap 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 both of the following are true regarding the Enrolled Dependent child:

- Is not able to be self-supporting because of mental retardation or physical handicap.
- Depends mainly on the Participant for support.

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

We will ask you to furnish the Claims Administrator with proof of the child's incapacity and dependency within 60 days of the date coverage would otherwise have ended because the child reached a certain age. Before the Claims Administrator agrees to this extension of coverage for the child, the Claims Administrator may require that a Physician chosen by us examine the child. We will pay for that examination.

The Claims Administrator may continue to ask you for proof that the child continues to meet these conditions of incapacity and dependency. 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 60 days of the Claims Administrator's request as described above, coverage for that child will end.

To continue reading, go to right column on this page.

Continuation of Coverage and Conversion

If your coverage ends under the Plan, you may be entitled to elect continuation coverage (coverage that continues on in some form) in accordance with federal law.

Continuation coverage under COBRA (the federal Consolidated Omnibus Budget Reconciliation Act) is available only to Plans that are subject to the terms of COBRA. You can contact your Plan Administrator to determine if we are subject to the provisions of COBRA.

If you selected continuation coverage under a prior plan which was then replaced by coverage under this Plan, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed below, whichever is earlier.

Continuation Coverage under Federal Law (COBRA)

Much of the language in this section comes from the federal law that governs continuation coverage. You should call your Plan Administrator if you have questions about your right to continue coverage.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who was covered under the Plan on the day before a qualifying event:

- A Participant.
- A Participant's Enrolled Dependent, including with respect to the Participant's children, a child born to or placed for adoption with the Participant during a period of continuation coverage under federal law.

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- A Participant's former spouse or Same-Sex Domestic Partner.

Qualifying Events for Continuation Coverage under Federal Law (COBRA)

If the coverage of a Qualified Beneficiary would ordinarily terminate due to one of the following qualifying events, then the Qualified Beneficiary is entitled to continue coverage. The Qualified Beneficiary is entitled to elect the same coverage that she or he had on the day before the qualifying event.

The qualifying events with respect to an employee who is a Qualified Beneficiary are:

A. Termination of employment, for any reason other than gross misconduct.
B. Reduction in the Participant's hours of employment.

With respect to a Participant's spouse or dependent child who is a Qualified Beneficiary, the qualifying events are:

A. Termination of the Participant's employment (for reasons other than the Participant's gross misconduct).
B. Reduction in the Participant's hours of employment.
C. Death of the Participant.
D. Divorce or legal separation of the Participant or dissolution of your Same-Sex Domestic Partnership.
E. Loss of eligibility by an Enrolled Dependent who is a child.
F. Entitlement of the Participant to Medicare benefits.
G. The Plan Sponsor's commencement of a bankruptcy under Title 11, United States Code. This is also a qualifying event for any retired Participant and his or her Enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

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Notification Requirements and Election Period for Continuation Coverage under Federal Law (COBRA)

Notification Requirements for Qualifying Event

The Participant or other Qualified Beneficiary must notify the Plan Administrator within 60 days of the latest of the date of the following events:

- The Participant's divorce, legal separation, or dissolution of a Same-Sex Domestic Partnership or an Enrolled Dependent's loss of eligibility as an Enrolled Dependent.
- The date the Qualified Beneficiary would lose coverage under the Plan.
- The date on which the Qualified Beneficiary is informed of his or her obligation to provide notice and the procedures for providing such notice.

The Participant or other Qualified Beneficiary must also notify the Plan Administrator when a second qualifying event occurs, which may extend continuation coverage.

If the Participant or other Qualified Beneficiary fails to notify the Plan Administrator of these events within the 60 day period, the Plan Administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If a Participant is continuing coverage under federal law, the Participant must notify the Plan Administrator within 60 days of the birth or adoption of a child.

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Notification Requirements for Disability Determination or Change in Disability Status

The Participant or other Qualified Beneficiary must notify the Plan Administrator as described under "Terminating Events for Continuation Coverage under Federal Law (COBRA)," subsection A. below.

The notice requirements will be satisfied by providing written notice to your Agency Benefit Coordinator or the Employee Benefits Division at the address stated in Attachment II to this Certificate of Coverage. The contents of the notice must be such that the Plan Administrator is able to determine the covered employee and Qualified Beneficiary or Qualified Beneficiaries, the qualifying event or disability, and the date on which the qualifying event occurred.

None of the above notice requirements will be enforced if the Participant or other Qualified Beneficiary is not informed of his or her obligations to provide such notice.

After providing notice to the Plan Administrator, the Qualified Beneficiary shall receive the continuation coverage and election notice. Continuation coverage must be elected by the later of 60 days after the qualifying event occurs; or 60 days after the Qualified Beneficiary receives notice of the continuation right from the Plan Administrator.

The Qualified Beneficiary's initial premium due to the Plan Administrator must be paid on or before the 45th day after electing continuation.

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain Participants who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of

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individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These Participants are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If a Participant qualifies or may qualify for assistance under the Trade Act of 1974, he or she should contact the Plan Administrator for additional information. The Participant must contact the Plan Administrator promptly after qualifying for assistance under the Trade Act of 1974 or the Participant will lose his or her special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that Plan coverage was lost, but begins on the first day of the special second election period.

Terminating Events for Continuation Coverage under Federal Law (COBRA)

Continuation under the Plan will end on the earliest of the following dates:

A. Eighteen months from the date of the qualifying event, if the Qualified Beneficiary's coverage would have ended because the Participant's employment was terminated or hours were reduced (i.e., qualifying events A and B).

   If a Qualified Beneficiary is determined to have been disabled under the Social Security Act at any time within the first 60 days of continuation coverage for qualifying event A or B. then the Qualified Beneficiary may elect an additional eleven months of

To continue reading, go to left column on next page.

continuation coverage (for a total of twenty-nine months of continued coverage) subject to the following conditions:

— Notice of such disability must be provided within the latest of 60 days after:
  - the determination of the disability; or
  - the date of the qualifying event; or
  - the date the Qualified Beneficiary would lose coverage under the Plan; and
  - in no event later than the end of the first eighteen months.

— The Qualified Beneficiary must agree to pay any increase in the required premium for the additional eleven months.

— If the Qualified Beneficiary who is entitled to the eleven months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional eleven months of continuation coverage.

Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

B. Thirty-six months from the date of the qualifying event for an Enrolled Dependent whose coverage ended because of the death of the Participant, divorce or legal separation of the Participant, or loss of eligibility by an Enrolled Dependent who is a child (i.e. qualifying events C, D, or E).

C. With respect to Qualified Beneficiaries, and to the extent that the Participant was entitled to Medicare prior to the qualifying event:

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— Eighteen months from the date of the Participant's termination of employment or work hours being reduced; or

— Thirty-six months from the date of the Participant's Medicare entitlement, if a second qualifying event (that was due to either the Participant's termination of employment or the Participant's work hours being reduced) occurs prior to the expiration of the eighteen months.

D. With respect to Qualified Beneficiaries, and to the extent that the Participant became entitled to Medicare subsequent to the qualifying event:

— Thirty-six months from the date of the Participant's termination from employment or work hours being reduced (first qualifying event) if:
  - The Participant's Medicare entitlement occurs within the eighteen month continuation period; and
  - Absent the first qualifying event, the Medicare entitlement would have resulted in a loss of coverage for the Qualified Beneficiary under the group health plan.

E. The date coverage terminates under the Plan for failure to make timely payment of the premium.

F. The date, after electing continuation coverage, that coverage is first obtained under any other group health plan. If such coverage contains a limitation or exclusion with respect to any pre-existing condition, continuation shall end on the date such limitation or exclusion ends. The other group health coverage shall be primary for all health services except those health services that are subject to the pre-existing condition limitation or exclusion.

G. The date, after electing continuation coverage, that the Qualified Beneficiary first becomes entitled to Medicare, except that this shall not apply in the event that coverage was terminated because the Plan Sponsor filed for bankruptcy, (i.e. qualifying

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event G). If the Qualified Beneficiary was entitled to continuation because the Plan Sponsor filed for bankruptcy, (i.e. qualifying event G) and the retired Participant dies during the continuation period, then the other Qualified Beneficiaries shall be entitled to continue coverage for thirty-six months from the date of the Participant's death.

H. The date the entire Plan ends.

I. The date coverage would otherwise terminate under the Plan as described in this section under the heading *Events Ending Your Coverage*.

Uniformed Services Employment and Reemployment Rights Act

A Participant who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue coverage under the Plan for the Participant and the Participant's Enrolled Dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1984, as amended (USERRA).

The terms "Uniformed Services" or "Military Service" mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified to continue coverage pursuant to USERRA, Participants may elect to continue coverage under the Plan by notifying the Plan Administrator in advance, and providing payment of any required contribution for the health coverage. This may include the amount the Plan Administrator normally pays on a Participant's behalf. If a Participant's Military Service is for a period of time less than 31 days,

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the Participant may not be required to pay more than the regular contribution amount, if any, for continuation of health coverage.

A Participant may continue Plan coverage under USERRA for up to the lesser of:

- The 24 month period beginning on the date of the Participant's absence from work; or
- The day after the date on which the Participant fails to apply for, or return to, a position of employment.

Regardless of whether a Participant continues health coverage, if the Participant returns to a position of employment, the Participant's health coverage and that of the Participant's eligible Dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on a Participant or the Participant's eligible Dependents in connection with this reinstatement, unless a Sickness or Injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should call the Plan Administrator if you have questions about your rights to continue health coverage under USERRA.

Conversion

If your coverage terminates for one of the reasons described below, you may apply for conversion coverage without furnishing evidence of insurability.

Reasons for termination:

- You cease to be eligible as a Participant or Enrolled Dependent; or
- Continuation coverage ends.

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This right to conversion coverage is contingent upon the exhaustion of COBRA continuation coverage.

Application and payment of the initial payment must be made to our designated carrier within 31 days after coverage ends under this Plan. Conversion coverage will be issued in accordance with the terms and conditions the designated carrier has in effect at the time of application. Conversion coverage may be substantially different from coverage provided under this Plan.

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Section 9: General Legal Provisions

This section provides you with information about:
- General legal provisions concerning the Plan.

Plan Document

This Certificate of Coverage presents an overview of your Benefits. In the event of any discrepancy between this Certificate of Coverage and the official Plan Document, the Plan Document shall govern.

Relationship with Providers

The relationships between us, the Claims Administrator, and Network providers are solely contractual relationships between independent contractors. Network providers are not our agents or employees. Nor are they agents or employees of the Claims Administrator. Neither we nor any of our employees are agents or employees of Network providers.

We do not provide health care services or supplies, nor do we practice medicine. Instead, we pay Benefits. Network providers are independent practitioners who run their own offices and facilities. The credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. Network providers are not our employees or employees of the Claims Administrator; nor do we have any other relationship with Network providers such as

To continue reading, go to right column on this page.

principal-agent or joint venture. Neither we nor the Claims Administrator are liable for any act or omission of any provider.

The Claims Administrator is not considered to be an employer of the Plan Administrator for any purpose with respect to the administration or provision of benefits under this Plan.

We and the Plan Administrator are solely responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of Benefits.
- Notifying you of the termination or modifications to the Plan.

Your Relationship with Providers

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

- You are responsible for choosing your own provider.
- 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 us is that of employer and employee, Dependent or other classification as defined in the Plan.

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Incentives to Providers

The Claims Administrator pays 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.
- Capitation - a group of Network providers receives a monthly payment for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

The methods used to pay specific Network providers may vary. From time to time, the payment method may change. If you have questions about whether your Network provider's contract includes any financial incentives, we encourage you to discuss those questions with your provider. You may also contact the Claims Administrator at the telephone number on your ID card. They 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.

Incentives to You

Sometimes the Claims Administrator may offer coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision

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about whether or not to participate is yours alone but we recommend that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. Contact the Claims Administrator if you have any questions.

Rebates and Other Payments

We and the Claims Administrator may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. We and the Claims Administrator do not pass these rebates on to you, nor are they taken into account in determining your Copayments.

Interpretation of Benefits

We and the Claims Administrator have sole and exclusive discretion to do all of the following:

- Interpret Benefits under the Plan.
- Interpret the other terms, conditions, limitations and exclusions of the Plan, including this COC and any Riders and Amendments.
- Make factual determinations related to the Plan and its Benefits.

We and the Claims Administrator may delegate this discretionary authority to other persons or entities who provide services in regard to the administration of the Plan.

In certain circumstances, for purposes of overall cost savings or efficiency, we may, in our sole 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.

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Administrative Services

We may, in our sole discretion, arrange for various persons or entities to provide administrative services in regard to the Plan, 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 Plan

We reserve the right, in our sole discretion and without your approval, to change, interpret, modify, withdraw or add Benefits or terminate the Plan. Plan Amendments and Riders are effective on the date we specify.

Any provision of the Plan which, on its effective date, is in conflict with the requirements of federal statutes or regulations, or applicable state law provisions not otherwise preempted by ERISA (of the jurisdiction in which the Plan is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

Any change or amendment to or termination of the Plan, its benefits or its terms and conditions, in whole or in part, shall be made solely in a written amendment (in the case of a change or amendment) or in a written resolution (in the case of a termination), whether prospective or retroactive, to the Plan, in accordance with the procedures established by us. Covered Persons will receive notice of any material modification to the Plan. No one has the authority to make any oral modification to the COC.

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Clerical Error

If a clerical error or other mistake occurs, that error does not create a right to Benefits. These errors include, but are not limited to, providing misinformation on eligibility or Benefit coverages or entitlements. It is your responsibility to confirm the accuracy of statements made by us or our designees, including the Claims Administrator, in accordance with the terms of this COC and other Plan documents.

Information and Records

At times we or the Claims Administrator may need additional information from you. You agree to furnish us and/or the Claims Administrator with all information and proofs that we may reasonably require regarding any matters pertaining to the Plan. If you do not provide this information when we request it, we may delay or deny payment of your Benefits.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish us or the Claims Administrator with all information or copies of records relating to the services provided to you. We or the Claims Administrator 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 Participant's enrollment form. We and the Claims Administrator agree that such information and records will be considered confidential.

We and the Claims Administrator have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of the Plan, we, the

To continue reading, go to left column on next page.

Claims Administrator, and our related entities may use and transfer the information gathered under the Plan for research and analytic purposes.

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, we or the Claims Administrator will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Such designees have the same rights to this information as the Plan Administrator.

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 Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Medicare Eligibility

Benefits under the Plan are not intended to supplement any coverage provided by Medicare. Nevertheless, in some

To continue reading, go to right column on this page.

circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled under the Plan.

If you are eligible for or enrolled in Medicare, please read the following information carefully.

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Plan), you **should** enroll for and maintain coverage under both Medicare Part A and Part B. If you don't enroll and maintain that coverage, and if we are the secondary payer as described in (Section 7: Coordination of Benefits), we will pay Benefits under the Plan as if you were covered under both Medicare Part A and Part B. As a result, you will be responsible for the costs that Medicare would have paid and you will incur a larger out-of-pocket cost.

If you are enrolled in a Medicare Advantage (Medicare Part C) plan on a primary basis (Medicare pays before Benefits under the Plan), you **should** follow all rules of that plan that require you to seek services from that plan's participating providers. When we are the secondary payer, we will pay any Benefits available to you under the Plan as if you had followed all rules of the Medicare Advantage plan. You will be responsible for any additional costs or reduced Benefits that result from your failure to follow these rules, and you will incur a larger out-of-pocket cost.

Subrogation and Reimbursement

The Plan has a right to subrogation and reimbursement, as defined below.

Right to Subrogation

The right to subrogation means the Plan is substituted to any legal claims that you may be entitled to pursue for Benefits that the Plan

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has paid. Subrogation applies when the Plan has paid Benefits for a Sickness or Injury for which a third party is considered responsible, e.g. an insurance carrier if you are involved in an auto accident.

The Plan shall be subrogated to, and shall succeed to, all rights of recovery from any or all third parties, under any legal theory of any type, for 100 percent of any services and Benefits the Plan has paid on your behalf relating to any Sickness or Injury caused by any third party.

Right to Reimbursement

The right to reimbursement means that if a third party causes a Sickness or Injury for which you receive a settlement, judgment, or other recovery, you must use those proceeds to fully return to the Plan 100% of any Benefits you received for that Sickness or Injury.

Third Parties

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- The Plan Sponsor.
- Any person or entity who is or may be obligated to provide you with benefits or payments under:
  - Underinsured or uninsured motorist insurance.
  - Medical provisions of no-fault or traditional insurance (auto, homeowners or otherwise).
  - Workers' compensation coverage.
  - Any other insurance carrier or third party administrator.

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Subrogation and Reimbursement Provisions

As a Covered Person, you agree to the following:

- The Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries, or pay any of your associated costs, including attorneys' fees. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- The Plan may enforce its subrogation and reimbursement rights regardless of whether you have been "made whole" (fully compensated for your injuries and damages).
- You will cooperate with the Plan and its agents in a timely manner to protect its legal and equitable rights to subrogation and reimbursement, including, but not limited to:
  - Complying with the terms of this section.
  - Providing any relevant information requested.
  - Signing and/or delivering documents at its request.
  - Appearing at medical examinations and legal proceedings, such as depositions or hearings.
  - Obtaining the Plan's consent before releasing any party from liability or payment of medical expenses.
- If you receive payment as part of a settlement or judgment from any third party as a result of a Sickness or Injury, and the Plan

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alleges some or all of those funds are due and owed to it, you agree to hold those settlement funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the Benefits the Plan has paid.

- If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- You will assign to the Plan all rights of recovery against third parties to the extent of Benefits the Plan has provided for a Sickness or Injury caused by a third party.
- The Plan's rights will not be reduced due to your own negligence.
- The Plan may file suit in your name and take appropriate action to assert its rights under this section. The Plan is not required to pay you part of any recovery it may obtain from a third party, even if it files suit in your name.
- The provisions of this section apply to the parents, guardian, or other representative of an Enrolled Dependent child who incurs a Sickness or Injury caused by a third party.
- In case of your wrongful death, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs.
- Your failure to cooperate with the Plan or its agents is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan.
- If a third party causes you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer a Covered Person.

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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 either 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.
- All or some of the payment we made exceeded the Benefits under the Plan.

The refund equals the amount we paid in excess of the amount we should have paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help us get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits that are payable under the Plan. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

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Section 10: Glossary of Defined Terms

This section:
- Defines the terms used throughout this COC.
- Is not intended to describe Benefits.

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.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health Services or Substance Use Disorder Services on an outpatient or inpatient basis.

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

Autism Spectrum Disorders - a group of neurobiological disorders that includes *Autistic Disorder*, *Rhett's Syndrome*, *Asperger's Disorder,*

To continue reading, go to right column on this page.

Childhood Disintegrated Disorder, and a *Pervasive Development Disorders Not Otherwise Specified (PDDNOS).*

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

Body Mass Index (BMI) – a practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

BMI – see Body Mass Index (BMI).

Cancer Resource Services - the program made available by the Plan Sponsor to Participants. The Cancer Resource Services program provides information to Participants or their Enrolled Dependents with cancer and offers access to additional cancer centers for the treatment of cancer.

Chiropractic Treatment - the therapeutic application of chiropractic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

Claims Administrator - the company (including its affiliates) that provides certain claim administration services for the Plan.

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

Copayment - the charge you are required to pay for certain Covered Health Services. A Copayment may be either a set dollar amount or a percentage of Eligible Expenses.

To continue reading, go to left column on next page.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator on our behalf.

Covered Health Service(s) -those health services provided for the purpose of preventing, diagnosing or treating a Sickness, Injury, Mental Illness, Substance Use Disorder, or their symptoms.

A Covered Health Service is a health care service or supply described in (Section 1: What's Covered--Benefits) as a Covered Health Service, which is not excluded under (Section 2: What's Not Covered--Exclusions).

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

Custodial Care - services that:

- Are non-health related services, such as assistance in activities of daily living (including but not limited to feeding, dressing, bathing, transferring and ambulating); or
- Are health-related services which do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the service is not changing; or
- Do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Dependent - the Participant's legal spouse or dependent child of the Participant or the Participant's spouse. All references to the spouse of a Participant shall include a Same-Sex Domestic Partner. The term child includes any of the following:

- A biological child.

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- A stepchild.
- A grandchild.
- A legally adopted child.
- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Participant or the Participant's spouse.
- An unmarried child of any age who is or becomes disabled and dependent on you.
- A child who meets the State of Maryland definition of a Dependent.

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

- A Dependent includes any dependent child under 26 years of age.

The Participant must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy these conditions.

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.

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

Designated Facility - a facility that has entered into an agreement on behalf of the facility and its affiliated staff with the Claims Administrator or with an organization contracting on its behalf to

To continue reading, go to left column on next page.

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.

Domestic Partner - a person of the same sex with whom the Participant has established a Domestic Partnership.

Domestic Partnership - an individual of the same sex with whom you have established a domestic partnership as described below.

A domestic partnership is a relationship between a Participant and one other person of the same sex. Both persons must meet **all** of the following criteria:

- Be of the same gender;
- Be at least 18 years old;
- Not be related to each other by blood or marriage within four degrees of consanguinity under civil law rule;
- Not be married, in a civil union, or in a domestic partnership with another individual;
- Have been in a committed relationship of mutual interdependence for at least 12 consecutive months 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.

Durable Medical Equipment - medical equipment that is all of the following:

- Can withstand repeated use.
- Is not disposable.
- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.

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- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Is appropriate for use in the home.

Eligible Expenses - for Covered Health Services incurred while the Plan is in effect, Eligible Expenses are determined as stated below:

Eligible Expenses are based on either of the following:

- When Covered Health Services are received from Network providers, Eligible Expenses are the contracted fee(s) with that provider; or
- When Covered Health Services are received from non-Network providers as a result of an Emergency or as otherwise arranged through the Claims Administrator, Eligible Expenses are billed charges unless a lower amount is negotiated

Eligible Person - a Participant who is an MSP employee (F/SGT and below) who meets the state's eligibility criteria.

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

Experimental or Investigational Services - medical, surgical, diagnostic, psychiatric, Substance Use Disorder or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time a determination is made regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.

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- Subject to review and approval by any institutional review board for the proposed use.
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

If you have a life-threatening Sickness or condition (one which is likely to cause death within one year of the request for treatment) we may, in our discretion, determine that an Experimental or Investigational Service meets the definition of a Covered Health Service for that Sickness or condition. For this to take place, we must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Group – the State of Maryland.

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

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

- 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; and
- Has 24 hour nursing services.

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

To continue reading, go to right column on this page.

Infertility - the inability to achieve Pregnancy after one (1) year of unprotected intercourse. Services to achieve Pregnancy after an adequate work-up of habitual miscarriage will be covered under the infertility benefit after the above criteria is met.

Initial Enrollment Period - the initial period of time, as determined by the Plan Administrator, during which Eligible Persons may enroll themselves and their Dependents under the Plan.

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

Inpatient Rehabilitation Facility - a Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive 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.

Kidney Resource Services (KRS) – a program administered by UnitedHealthcare or its affiliates made available to you by the State of Maryland. The KRS program provides:

- Specialized consulting services to Participants and enrolled Dependents with ESRD or chronic kidney disease.
- Access to dialysis centers with expertise in treating kidney disease.

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- Guidance for the patient on the prescribed plan of care.

Medical Emergency or Emergency Health Services - health care services that are provided in a Hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in at least one of the following:

- Placing the patient's health in jeopardy.
- Serious impairment of bodily functions.
- Serious dysfunction of any bodily organ or part.

If a Primary Physician directs a Covered Person to the emergency room, the Plan pays the claim regardless of the diagnosis.

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 the Claims Administrator, that provides or arranges Mental Health Services and Substance Use Disorder Services for which Benefits are available under the Plan.

Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current *Diagnostic and Statistical Manual*

To continue reading, go to right column on this page.

of the American Psychiatric Association, unless those services are specifically excluded under the Plan.

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with the Claims Administrator's affiliate to participate in the Claims Administrator's Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services. The Claims Administrator's affiliates are those entities affiliated with them through common ownership or control with the Claims Administrator or with its 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 the Claims Administrator's 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.

Open Enrollment Period - a period of time that follows the Initial Enrollment Period during which Eligible Persons may enroll themselves and Dependents under the Plan, as determined by us.

Partial Hospitalization/Day Treatment - a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

Participant - an Eligible Person who is properly enrolled under the Plan. The Participant is the person (who is not a Dependent) on whose behalf the Plan is established.

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Pharmaceutical Products - FDA-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under the Plan.

Physician - any Doctor of Medicine, "M.D.", or Doctor of Osteopathy, "D.O.", 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 Plan.

Plan - EPO Plan for State of Maryland Health Benefit Plan.

Plan Administrator - is State of Maryland or its designee.

Plan Sponsor - State of Maryland. References to "we", "us", and "our" throughout the COC refer to the Plan Sponsor.

Pregnancy - includes all of the following:

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

Primary Physician - a Network Physician that you select to be responsible for providing or coordinating all Covered Health Services. A Primary Physician has entered into an agreement with the Claims Administrator to provide primary care health services to Covered Persons. The majority of his or her practice generally

To continue reading, go to right column on this page.

includes pediatrics, internal medicine, obstetrics/gynecology, or family or general practice.

Residential Crisis Services - intensive mental health and support services that are:

- Provided to a child or an adult with a Mental Illness who is experiencing or is at risk of a psychiatric crisis that would impair the individuals 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;

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— evaluation and diagnosis;

— counseling; and

— referral and orientation to specialized community resources.

A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital.

Rider - any attached written description of additional Covered Health Services not described in this COC. Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of the Plan except for those that are specifically amended in the Rider.

Same-Sex Domestic Partner – see Domestic Partner.

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

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this COC does not include Mental Illness or Substance Use Disorder, regardless of the cause or origin of the Mental Illness or Substance Use Disorder.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

Substance Use Disorder Services - Covered Health Services for the diagnosis and treatment of alcoholism and Substance Use Disorder 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

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Association does not mean that treatment of the disorder is a Covered Health Service.

Transitional Care - Mental Health Services/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, 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 arrangement 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.

Unproven Services - services that are not consistent with conclusions of prevailing medical research which demonstrate that the health service has a beneficial effect on health outcomes and that are not based on trials that meet either of the following designs.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive

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standard therapy. The comparison group must be nearly identical to the study treatment group.)

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we and the Claims Administrator may, in our discretion, determine that an Unproven Service meets the definition of a Covered Health Service for that Sickness or condition. For this to take place, we and the Claims Administrator must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Urgent Care Center - a facility, other than a Hospital, 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.

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Riders, Amendments, Notices

Attachment I

Attachment II

Attachment III

Addendum - Resources To Help You Stay Healthy

Addendum - UnitedHealth Allies

Attachment I

Women's Health and Cancer Rights Act of 1998

As required by the Women's Health and Cancer Rights Act of 1998, we provide Benefits under the Plan for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

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Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health Plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your issuer.

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Attachment II

Additional Plan Description

Claims Administrator: The company which provides certain administrative services for the Plan Benefits described in this Certificate of Coverage.

United HealthCare Services, Inc.
Attn: Claims
185 Asylum Street
Hartford, CT 06103

The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of benefits under the Plan Sponsor's Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

Type of Administration of the Plan: The Plan Sponsor provides certain administrative services in connection with its Plan. The Plan Sponsor may, from time to time in its sole discretion, contract with outside parties to arrange for the provision of other administrative services including arrangement of access to a Network Provider; claims processing services, including coordination of benefits and subrogation; utilization management and complaint resolution assistance. This external administrator is referred to as the Claims Administrator. For Benefits as described in this Certificate of

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Coverage, the Plan Sponsor also has selected a provider network established by United HealthCare Services, Inc.. The named fiduciary of the Plan is the State of Maryland, the Plan Sponsor.

The Plan Sponsor retains all fiduciary responsibilities with respect to the Plan except to the extent the Plan Sponsor has delegated or allocated to other persons or entities one or more fiduciary responsibility with respect to the Plan

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Attachment III

Patient Protection and Affordable Care Act ("PPACA")

Patient Protection Notices

The Claims Administrator generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Claims Administrator's network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator at the Customer Service number on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Claims Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Claims Administrator at the Customer Service number on the back of your ID card.

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Addendum - Resources To Help You Stay Healthy

The State of Maryland believes in giving you the tools you need to be an educated health care consumer. To that end, the State of Maryland has made available several convenient educational and support services, accessible by phone and the Internet, which can help you to:

- Take care of yourself and your family members.
- Manage a chronic health condition.
- Navigate the complexities of the health care system.

NOTE:
Information obtained through the services identified in this section is based on current medical literature and on Physician review. It is not intended to replace the advice of a doctor. The information is intended to help you make better health care decisions and take a greater responsibility for your own health. The Claims Administrator and the State of Maryland are not responsible for the results of your decisions from the use of the information, including, but not limited to, your choosing to seek or not to seek professional medical care, or your choosing or not choosing specific treatment based on the text.

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www.myuhc.com

UnitedHealthcare's member website, **www.myuhc.com**, provides information at your fingertips anywhere and anytime you have access to the Internet. **www.myuhc.com** opens the door to a wealth of health information and convenient self-service tools to meet your needs.

Health Information

With **www.myuhc.com** you can:

- Research a health condition and treatment options to get ready for a discussion with your Physician.
- Search for Network providers available in your Plan through the online provider directory.
- Access all of the content and wellness topics from NurseLine including Live Nurse Chat 24 hours a day, seven days a week.
- Complete a health risk assessment to identify health habits you can improve, learn about healthy lifestyle techniques and access health improvement resources.
- Use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area.
- Use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

Self-Service Tools

Visit **www.myuhc.com** and:

- Make real-time inquiries into the status and history of your claims.
- View eligibility and Plan Benefit information, including Copayments.

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- View and print all of your Explanation of Benefits (EOBs) online.
- Order a new or replacement ID card or print a temporary ID card.

Registering on www.myuhc.com
If you have not already registered as a **www.myuhc.com** subscriber, simply go to **www.myuhc.com** and click on "Register Now." Have your UnitedHealthcare ID card handy. The enrollment process is quick and easy.

Health Assessment

You, your Spouse and your Dependent children are invited to learn more about your health and wellness at **www.myuhc.com** and are encouraged to participate in the online health assessment. The health assessment is an interactive questionnaire designed to help you identify your healthy habits as well as potential health risks.

Your health assessment is kept confidential. Completing the assessment will not impact your Benefits or eligibility for Benefits in any way.

To find the health assessment, log in to **www.myuhc.com**. After logging in, access your personalized *Health & Wellness* page and click the *Health Assessment* link. If you need any assistance with the online assessment, please call the number on the back of your ID card.

Health Improvement Plan

You can start a Health Improvement Plan at any time. This plan is created just for you and includes information and interactive tools, plus online health coaching recommendations based on your profile.

Online coaching is available for:

- Nutrition.

To continue reading, go to right column on this page.

- Exercise.
- Weight management.
- Stress.
- Smoking cessation.
- Diabetes.
- Heart health.

To help keep you on track with your Health Improvement Plan and online coaching, you'll also receive personalized messages and reminders – the State of Maryland's way of helping you meet your health and wellness goals.

Optum® NurseLine℠

Optum NurseLine is a toll-free telephone service that puts you in immediate contact with an experienced registered nurse any time, 24 hours a day, seven days a week. Nurses can provide health information for routine or urgent health concerns. When you call, a registered nurse may refer you to any additional resources that the State of Maryland has available to help you improve your health and well-being or manage a chronic condition. Call any time when you want to learn more about:

- A recent diagnosis.
- A minor Sickness or Injury.
- Men's, women's, and children's wellness.
- How to take prescription drugs safely.
- Self-care tips and treatment options.
- Healthy living habits.
- Any other health related topic.

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NurseLine gives you another convenient way to access health information. By calling the same toll-free number, you can listen to one of the Health Information Library's over 1,100 recorded messages, with over half in Spanish.

NurseLine is available to you at no cost. To use this convenient service, simply call the toll-free number on the back of your ID card or dial (888) 315-7257.

Note: If you have a Medical Emergency, call 911 instead of calling NurseLine.

Your child is running a fever and it's 1:00 AM. What do you do?
Call NurseLine toll-free at the number on your ID card, any time, 24 hours a day, seven days a week. You can count on NurseLine to help answer your health questions.

Live Nurse Chat

With NurseLine, you also have access to nurses online. To use this service, log onto **www.myuhc.com** and click "Live Nurse Chat" in the top menu bar. You'll instantly be connected with a registered nurse who can answer your general health questions any time, 24 hours a day, seven days a week. You can also request an e-mailed transcript of the conversation to use as a reference.

Note: If you have a Medical Emergency, call 911 instead of logging onto **www.myuhc.com**.

Live Events on www.myuhc.com

Periodically, **www.myuhc.com** hosts live events with leading health care professionals. After viewing a presentation, you can chat online with the experts. Topics include:

To continue reading, go to right column on this page.

- Weight control.
- Parenting.
- Heart disease.
- Relationships.
- Depression.

For details, or to participate in a live event, log onto **www.myuhc.com**.

Want to learn more about a condition or treatment?
Log on to **www.myuhc.com** and research health topics that are of interest to you. Learn about a specific condition, what the symptoms are, how it is diagnosed, how common it is, and what to ask your Physician.

Healthy Pregnancy Program

If you are pregnant and enrolled in the medical Plan, you can get valuable educational information and advice by calling the toll-free number on your ID card. This program offers:

- Pregnancy consultation to identify special needs.
- Written and on-line educational materials and resources.
- 24-hour toll-free access to experienced maternity nurses.
- A phone call from a care coordinator during your Pregnancy, to see how things are going.
- A phone call from a care coordinator approximately four weeks postpartum to give you information on infant care, feeding, nutrition, immunizations and more.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll

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within the first 12 weeks of Pregnancy. You can enroll any time, up to your 34th week. To enroll, call the toll-free number on the back of your ID card.

As a program participant, you can call any time, 24 hours a day, seven days a week, with any questions or concerns you might have.

Activation Campaigns

To help support you in your healthcare decisions, the Claims Administrator may send you and your covered Dependents materials focused on the following topics:

- Your health care experience.
- Your health and wellness.
- Value for your health care dollar.

UnitedHealth Premium℠ Program

The Claims Administrator designates Network Physicians and facilities as UnitedHealth Premium Program Physicians or facilities for certain medical conditions. Physicians and facilities are evaluated on two levels - quality and efficiency of care. The UnitedHealth Premium Program was designed to:

- Help you make informed decisions on where to receive care.
- Provide you with decision support resources.
- Give you access to Physicians and facilities across areas of medicine that have met UnitedHealthcare's quality and efficiency criteria.

For details on the UnitedHealth Premium Program including how to locate a UnitedHealth Premium Physician or facility, log onto **www.myuhc.com** or call the toll-free number on your ID card.

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HealtheNotes℠

UnitedHealthcare provides a service called HealtheNotes to help educate members and make suggestions regarding your medical care. HealtheNotes provides you and your Physician with suggestions regarding preventive care, testing or medications, potential interactions with medications you have been prescribed, and certain treatments. In addition, your HealtheNotes report may include health tips and other wellness information.

UnitedHealthcare makes these suggestions through a software program that provides retrospective, claims-based identification of medical care. Through this process patients are identified whose care may benefit from suggestions using the established standards of evidence based medicine as described in Section 10, *Defined Terms* under the definition of Covered Health Services.

If your Physician identifies any concerns after reviewing his or her HealtheNotes report, he or she may contact you if he or she believes it to be appropriate. In addition, you may use the information in your report to engage your Physician in discussions regarding your health and the identified suggestions. Any decisions regarding your care, though, are always between you and your Physician.

If you have questions or would like additional information about this service, please call the number on the back of your ID card.

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Addendum - UnitedHealth Allies

Introduction

This Addendum to the Certificate of Coverage provides discounts for select non-Covered Health Services from Physicians and health care professionals.

When the words "you" and "your" are used the Plan is referring to people who are Covered Persons as the term is defined in the Certificate of Coverage (COC). See (Section 10: Glossary) in the COC.

> ***Important***:
> UnitedHealth Allies is not a health insurance plan. You are responsible for the full cost of any services purchased, minus the applicable discount. Always use your health insurance plan for Covered Health Services described in the Certificate of Coverage (see (Section 1: What's Covered--Benefits)) when a benefit is available.

What is UnitedHealth Allies?

UnitedHealth Allies is a health value program that offers savings on certain products and services that are not Covered Health Services under your health plan.

Because this is not a health insurance plan, you are not required to receive a referral or submit any claim forms.

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Discounts through UnitedHealth Allies are available to you and your Enrolled Dependents as defined in the Certificate of Coverage in (Section 10: Glossary).

Selecting a Discounted Product or Service

A list of available discounted products or services can be viewed online at **www.healthallies.com** or by calling the number on the back of your ID card.

After selecting a health care professional and product or service, reserve the preferred rate and print the rate confirmation letter. If you have reserved a product or service with a customer service representative, the rate confirmation letter will be faxed or mailed to you.

> ***Important***:
> You must present the rate confirmation at the time of receiving the product or service in order to receive the discount.

Visiting Your Selected Health Care Professional

After reserving a preferred rate, make an appointment directly with the health care professional. Your appointment must be within ninety (90) days of the date on your rate confirmation letter.

Present the rate confirmation and your ID card at the time you receive the service. You will be required to pay the preferred rate directly to the health care professional at the time the service is received.

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Additional UnitedHealth Allies Information

Additional information on the UnitedHealth Allies program can be obtained online at **www.healthallies.com** or by calling the toll-free phone number on the back of your ID card.

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