Evidence of Coverage

The State of Maryland-State Law Enforcement Officers Labor Alliance
PPO Plan

Effective: January 1, 2014 through December 31, 2014

Group Number: 716450

UnitedHealthcare®
A UnitedHealth Group Company

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SECTION 1 – WELCOME

Quick Reference Box

- Member services, claim inquiries and Care Coordination[SM]: (800) 382-7513;
- Claims submittal address: UnitedHealthcare - Claims, P.O. Box 740800, Atlanta, GA 30374-0800; and
- Online assistance: **www.myuhc.com**.

The State of Maryland is pleased to provide you with this Evidence of Coverage (EOC), which describes the health Benefits available to you and your eligible dependents. It includes summaries of:

- who is eligible;
- services that are covered, called Covered Health Services;
- services that are not covered, called Exclusions;
- how Benefits are paid; and
- your rights and responsibilities under the Plan.

The State of Maryland intends to continue this Plan, but reserves the right, in its sole discretion, to modify, change, revise, amend or terminate the Plan at any time, for any reason, and without prior notice. This EOC is not to be construed as a contract of or for employment. If there should be an inconsistency between the contents of this summary and the contents of the Plan, your rights shall be determined under the Plan and not under this summary.

UnitedHealthcare is a private healthcare claims administrator. UnitedHealthcare's goal is to give you the tools you need to make wise healthcare decisions. UnitedHealthcare also helps your employer to administer claims. Although UnitedHealthcare will assist you in many ways, it does not guarantee any Benefits. The State of Maryland is solely responsible for paying Benefits described in this EOC.

Please read this EOC thoroughly to learn how the PPO Plan works. If you have questions contact your Agency Benefit Coordinator or the Employee Benefits Division or call the number on the back of your ID card.

How To Use This Evidence of Coverage

- Read the entire EOC, and share it with your eligible dependents. Then keep it in a safe place for future reference.
- Many of the sections of this EOC are related to other sections. You may not have all the information you need by reading just one section.
- You can request copies of your EOC and any future amendments by contacting your Agency Benefit Coordinator or the Employee Benefits Division.
- Capitalized words in the EOC have special meanings and are defined in Section 14, *Glossary*.
- If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in Section 14, *Glossary*.
- The State of Maryland is also referred to as Group.
- If there is a conflict between this EOC and any benefit summaries (other than Summaries of Material Modifications) provided to you, this EOC will control.

SECTION 2 - INTRODUCTION

What this section includes:

- Who's eligible for coverage under the Plan;
- The factors that impact your cost for coverage;
- Instructions and timeframes for enrolling yourself and your eligible Dependents;
- When coverage begins; and
- When you can make coverage changes under the Plan.

Eligibility

You are eligible to enroll in the Plan if you are an MSP employee (F/SGT and below) who meets the Group's eligibility criteria.

Your eligible Dependents may also participate in the Plan. An eligible Dependent is considered to be:

- your Spouse, as defined in Section 14, *Glossary* (the definition of Spouse includes same-sex Domestic Partners);
- your or your Spouse's child who is under age 26, including a natural child, stepchild, grandchild, a legally adopted child, a child placed for adoption or a child for whom you or your Spouse are the legal guardian;
- an unmarried child who is or becomes disabled prior to turning age 26 and is or becomes dependent upon you; or
- a child who meets the State of Maryland definition of a Dependent.

Note: Your Dependents may not enroll in the Plan unless you are also enrolled. If you and your Spouse are both covered under the PPO, you may each be enrolled as a Participant or be covered as a Dependent of the other person, but not both. In addition, if you and your Spouse are both covered under the PPO, only one parent may enroll your child as a Dependent.

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, as described in Section 13, *Other Important Information*.

Cost of Coverage

You and the State of Maryland share in the cost of the Plan. Your contribution amount depends on the Plan you select and the eligible dependents you choose to enroll.

For active state employees, your contributions are deducted from your paychecks on a before-tax basis in most cases. Before-tax dollars come out of your pay before federal income and Social Security taxes are withheld - and in most states, before state and local

taxes are withheld. This gives your contributions a special tax advantage and lowers the actual cost to you.

Your contributions are subject to review, and the State of Maryland reserves the right to change your contribution amount from time to time. You can obtain your current rate contributions by going to the Department of Budget & Management's Health Benefits website at www.dbm.maryland.gov/benefits.

How to Enroll

To enroll, contact your Agency Benefit Coordinator within 60 days of the date you first become eligible for medical Plan coverage. If you do not enroll within 60 days, you will need to wait until the next annual Open Enrollment to make your benefit elections unless you experience a family status change.

Each year during annual Open Enrollment, you have the opportunity to review and change your medical election. Any changes you make during Open Enrollment will become effective the beginning of the plan year.

Important
If you wish to change your benefit elections following your marriage, birth, adoption of a child, placement for adoption of a child or other family status change, you must contact your Agency Benefit Coordinator within 60 days of the event. Otherwise, you will need to wait until the next annual Open Enrollment to change your elections.

When Coverage Begins

Once the Employee Benefits Division receives your properly completed enrollment, coverage will begin either the first 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 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 (for active state employees, contractual employees, and satellite employees) or the Employee Benefits Division (for retirees) 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 (for active state employees, contractual employees, and satellite employees) or the Employee Benefits Division (for retirees) within 60 days of the birth, adoption, or placement.

Changing Your Coverage

You may make coverage changes during the year only if you experience a change in family status. The change in coverage must be consistent with the change in status (e.g., you cover

your Spouse following your marriage, your child following an adoption, etc.). The following are considered family status changes for purposes of the Plan:

- your marriage or divorce;
- dissolution of a domestic partnership;
- the birth, adoption, placement for adoption or legal guardianship of a child;
- a change in your Spouse's employment or involuntary loss of health coverage (other than coverage under the Medicare or Medicaid programs) under another employer's plan;
- loss of coverage due to the exhaustion of another employer's COBRA benefits, provided you were paying for premiums on a timely basis;
- the death of a Dependent;
- your Dependent child no longer qualifying as an eligible Dependent;
- a change in your or your Spouse's position or work schedule that impacts eligibility for health coverage;
- contributions were no longer paid by the employer (This is true even if you or your eligible Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer);
- you or your eligible Dependent who were enrolled in an HMO no longer live or work in that HMO's service area and no other benefit option is available to you or your eligible Dependent;
- benefits are no longer offered by the Plan to a class of individuals that include you or your eligible 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 contact your Agency Benefit Coordinator or the Employee Benefits Division within 60 days of termination);
- you or your Dependent become eligible for a premium assistance subsidy under Medicaid or SCHIP (you must contact your Agency Benefit Coordinator or the Employee Benefits Division within 60 days of determination of subsidy eligibility);
- a strike or lockout involving you or your Spouse; or
- a court or administrative order.

Unless otherwise noted above, if you wish to change your elections, you must contact your Agency Benefit Coordinator or the Employee Benefits Division within 60 days of the change in family status. Otherwise, you will need to wait until the next annual Open Enrollment.

While some of these changes in status are similar to qualifying events under COBRA, you, or your eligible Dependent, do not need to elect COBRA continuation coverage to take advantage of the special enrollment rights listed above. These will also be available to you or your eligible Dependent if COBRA is elected.

Note: Any child under age 26 who is placed with you for adoption will be eligible for coverage on the date the child is placed with you, even if the legal adoption is not yet final. If

you do not legally adopt the child, all medical Plan coverage for the child will end when the placement ends. No provision will be made for continuing coverage (such as COBRA coverage) for the child.

Change in Family Status - Example

Jane is married and has two children who qualify as Dependents. At annual Open Enrollment, she elects not to participate in the State of Maryland's medical plan, because her husband, Tom, has family coverage under his employer's medical plan. In June, Tom loses his job as part of a downsizing. As a result, Tom loses his eligibility for medical coverage. Due to this family status change, Jane can elect family medical coverage under the State of Maryland's medical plan outside of annual Open Enrollment.

SECTION 3 - HOW THE PLAN WORKS

What this section includes:

- In-Network and Out-of-Network Benefits;
- Eligible Expenses;
- Annual Deductible;
- Copayment;
- Out-of-Pocket Maximum; and
- Coinsurance.

In-Network and Out-of-Network Benefits

As a participant in this Plan, you have the freedom to choose the Physician or health care professional you prefer each time you need to receive Covered Health Services. The choices you make affect the amounts you pay, as well as the level of Benefits you receive and any benefit limitations that may apply.

You are eligible for the In-Network level of Benefits under this Plan when you receive Covered Health Services from Physicians and other health care professionals who have contracted with UnitedHealthcare to provide those services. For facility services, these are Benefits for Covered Health Services that are provided at a Network facility under the direction of either an In-Network or Out-of-Network Physician or other provider. In-Network Benefits include Physician services provided in an In-Network facility by an In-Network or an Out-of-Network anesthesiologist, emergency room Physician, consulting Physician, pathologist and radiologist. Emergency Health Services are always paid as In-Network Benefits.

Generally, when you receive Covered Health Services from a Network provider, you pay less than you would if you receive the same care from an Out-of-Network provider. Therefore, in most instances, your out-of-pocket expenses will be less if you use an In-Network provider.

If you choose to seek care outside the Network, the Plan generally pays Benefits at a lower level. You are required to pay the amount that exceeds the Eligible Expense. The amount in excess of the Eligible Expense could be significant, and this amount does not apply to the Out-of-Pocket Maximum. You may want to ask the Out-of-Network provider about their billed charges before you receive care. Emergency services received at an Out-of-Network Hospital are covered at the In-Network level.

Looking for an In-Network Provider?
In addition to other helpful information, **www.myuhc.com**, UnitedHealthcare's consumer website, contains a directory of health care professionals and facilities in UnitedHealthcare's Network. While In-Network status may change from time to time, **www.myuhc.com** has the most current source of Network information. Use **www.myuhc.com** to search for Physicians available in your Plan.

In-Network Providers

UnitedHealthcare or its affiliates arrange for health care providers to participate in a Network. To verify a provider's status orto locate a participating provider, you can call UnitedHealthcare at the toll-free number on your ID card or log onto **www.myuhc.com**.

In-Network providers are independent practitioners and are not employees of UnitedHealthcare.

Possible Limitations on Provider Use

If UnitedHealthcare determines that health care services are being used in a harmful or abusive manner, UnitedHealthcare has the right to select an In-Network Physician to coordinate all of your future Covered Health Services. If you don't make a selection within 31 days of the date you are notified, UnitedHealthcare has the right to select an In-Network Physician for you. In the event that you do not use the In-Network Physician to coordinate all of your care, any Covered Health Services you receive may be paid at the Out-of-Network level.

Eligible Expenses

Eligible Expenses are charges for Covered Health Services that are provided while the Plan is in effect, determined according to the definition in Section 14, *Glossary*. For certain Covered Health Services, the Plan will not pay these expenses until you have met your Annual Deductible. The State of Maryland has delegated to UnitedHealthcare the discretion and authority to decide whether a treatment or supply is a Covered Health Service as defined in this EOC and how the Eligible Expenses will be determined and otherwise covered under the Plan.

Don't Forget Your ID Card
Remember to show your UnitedHealthcare ID card every time you receive health care services from a provider. If you do not show your ID card, a provider has no way of knowing that you are enrolled under the Plan.

Annual Deductible

The Annual Deductible is the amount of Eligible Expenses you must pay each calendar year for covered Health Services before you are eligible to begin receiving Benefits. The Annual Deductible applies only to Out-of-Network Benefits for this Plan. The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year.

Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum benefit limit. As a result, the limited benefit will be reduced by the number of days or visits you used toward meeting the Annual Deductible.

Any amount you pay for medical expenses in the last three months of the previous calendar year, that is applied to the previous Deductible, will be carried over and applied to the current Deductible. This carry-over feature applies to the individual and family Deductible.

When a Covered Person was previously covered under a benefit plan that was replaced by the Plan, any amount already applied to that annual deductible provision of the prior plan will apply to the Annual Deductible provision under this Plan.

Copayment

A Copayment (Copay) is the amount you pay each time you receive certain Covered Health Services. The Copay is a flat dollar amount and is paid at the time of service or when billed by the provider. Copays do not count toward the Annual Deductible. If the Eligible Expense is less than the Copay, you are only responsible for paying the Eligible Expense and not the Copay.

Coinsurance

Coinsurance is the percentage of Eligible Expenses that you are responsible for paying. Coinsurance is a fixed percentage that applies to certain Covered Health Services after you meet the Annual Deductible.

Coinsurance – Example
Let's assume that you receive Plan Benefits for outpatient surgery from an Out-of-Network provider. Since the Plan pays 70% after you meet the Annual Deductible, you are responsible for paying the other 30%. This 30% is your Coinsurance.

Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum is the most you pay each calendar year for Covered Health Services. There are separate In-Network and Out-of-Network Out-of-Pocket Maximums for this Plan. If your eligible out-of-pocket expenses in a calendar year exceed the annual maximum, the Plan pays 100% of Eligible Expenses for Covered Health Services for the remainder of the calendar year.

Eligible Expenses charged by both In-Network and Out-of-Network providers apply toward both the In-Network individual and family Out-of-Pocket Maximums and the Out-of-Network individual and family Out-of-Pocket Maximums.

Copayments have a separate Out-of-Pocket Maximum.

The following table identifies what does and does not apply toward your In-Network and Out-of-Network Out-of-Pocket Maximums:

Plan Features	Applies to the In-Network Coinsurance and Deductible Out-of-Pocket Maximum?	Applies to the Out-of-Network Coinsurance and Deductible Out-of-Pocket Maximum?
Copays Separate Out of Pocket Maximum	No	No
Payments toward the Annual Deductible	N/A	Yes
Coinsurance Payments	Yes	Yes
Charges for non-Covered Health Services	No	No
The amounts of any reductions in Benefits you incur by not notifying Care Coordination℠	No	No
Charges that exceed Eligible Expenses	No	No

How the Plan Works - Example

The following example on page 11 illustrates how Annual Deductibles, Copays, Out-of-Pocket Maximums and Coinsurance work in practice.

Let's say Gary has individual coverage under the Plan. He has not met his Out-of-Network Annual Deductible and needs to see a Physician. The flow chart below shows what happens when he visits an In-Network Primary Care Physician versus an Out-of-Network Primary Care Physician.

In-Network Benefits

1. Gary goes to see an In-Network Primary Care Physician and presents his ID card.
2. He receives treatment from the Primary Care Physician. The Plan's Eligible Expense for the In-Network office visit equals $125.
3. On his way out, Gary pays a $15 Copay. Since In-Network Physician office visits are covered at 100% after the Copay, Gary has met his financial obligations for this office visit.
4. The Plan pays $110 ($125 Eligible Expense minus $15 Copay).

Out-of-Network Benefits

1. Gary goes to see an Out-of-Network Primary Care Physician and presents his ID card.
2. He receives treatment from the Primary Care Physician. The Eligible Expense for his visit is $175, however the Physician's fee is $225.
3. The Physician's office requests no payment, informing Gary that it will bill UnitedHealthcare directly.*
4. Gary is responsible for paying the Eligible Expense of $175 directly to the Physician, because he has not yet met his Annual Deductible.
5. Gary receives a bill from the Physician, and pays the Physician directly.
6. The Physician's office, at its discretion, might bill Gary for the remaining $50:

$225	-	$175	=	$50
(Physician's fee)		(Eligible Expense)		

Gary's $50 payment does not apply to his Annual Deductible or Out-of-Pocket Maximum.

7. UnitedHealthcare applies the $175 toward Gary's Annual Deductible and Out-of-Pocket Maximum.

*Although Out-of-Network providers have the right to request payment in full at the time of service, they bill UnitedHealthcare directly in most cases but there could be instances where you must file your own claim.

SECTION 4 - CARE COORDINATION℠

What this section includes:

- An overview of the Care Coordination℠ program; and
- Covered Health Services for which you need to contact Care Coordination℠.

UnitedHealthcare provides a program called Care Coordination℠ designed to encourage personalized, efficient care for you and your covered Dependents.

Care Coordination℠ nurses center their efforts on prevention, education, and closing any gaps in your care. The goal of the program is to ensure you receive the most appropriate and cost-effective services available. A Care Coordination℠ nurse is notified when you or your provider calls the toll-free number on your ID card regarding an upcoming treatment or service.

Care Coordination℠ nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components and notification requirements are subject to change without notice. As of the publication of this EOC, the Care Coordination℠ program includes:

- **Admission counseling** - For upcoming inpatient Hospital admissions for certain conditions, a Care Coordination℠ nurse may call you to help answer your questions and to make sure you have the information and support you need for a successful recovery.
- **Inpatient care advocacy** - If you are hospitalized, a Care Coordination℠ nurse will work with your Physician to make sure you are getting the care you need and that your Physician's treatment plan is being carried out effectively.
- **Readmission Management** - This program serves as a bridge between the Hospital and your home if you are at high risk of being readmitted. After leaving the Hospital, if you have a certain chronic or complex condition, you may receive a phone call from a Care Coordination℠ nurse to confirm that medications, needed equipment, or follow-up services are in place. The Care Coordination℠ nurse will also share important health care information, reiterate and reinforce discharge instructions, and support a safe transition home.
- **Risk Management** - Designed for participants with certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies. Participants may receive a phone call from a Care Coordination℠ nurse to discuss and share important health care information related to the participant's specific chronic or complex condition.

If you do not receive a call from a Care Coordination℠ nurse but feel you could benefit from any of these programs, please call the toll-free number on your ID card.

Requirements for Notifying Care Coordination℠

There are some services for which you are responsible for notifying Care Coordination℠ prior to receiving these services. In many cases, your Benefits will be reduced if Care Coordination℠ is not notified.

The services that require Care Coordination℠ notification are:

- ambulance – non-emergent air and ground;
- cleft lip/palate;
- Clinical Trials;
- cochlear implants;
- Congenital Heart Disease services;
- dental services - accident only;
- Durable Medical Equipment for items that will cost more than $1,000 to purchase or rent;
- Gender Dysphoria;
- home health care;
- hospice care - inpatient;
- Hospital Inpatient Stay, including emergency admission;
- infertility treatment;
- maternity care that exceeds the delivery timeframes as described in Section 6*, Additional Coverage Details*;
- obesity surgery;
- outpatient therapeutics - dialysis;
- private duty nursing - outpatient;
- prosthetic devices for items that will cost more than $1,000;
- Reconstructive Procedures;
- rehabilitation services as follows:
  - physical therapy after the sixth visit;
  - occupational therapy after the sixth visit; and
  - all speech therapy visits;
- Skilled Nursing Facility/Inpatient Rehabilitation Facility Services;
- temporomandibular joint services; and
- transplantation services.

The following procedures also require that you notify Care Coordination℠ prior to receiving services in order for Care Coordination℠ to determine if they are Covered Health Services:

- breast reduction and reconstruction (except following cancer surgery);

- surgical treatment of sleep apnea;
- vein stripping, ablation and sclerotherapy (an injection of a chemical to treat varicose veins); and
- blepharoplasty (surgery to correct aging of the eyelids).

These services will not be covered when considered to be Cosmetic Procedures, as defined in Section 14, *Glossary*.

For notification timeframes, and reductions in Benefits that apply if you do not notify Care Coordination℠, see Section 6, *Additional Coverage Details*.

Contacting Care Coordination℠ is easy.
Simply call the toll-free number on your ID card.

Special Note Regarding Medicare

If you are enrolled in Medicare and Medicare pays benefits before the Plan, you are not required to notify Care Coordination℠ before receiving Covered Health Services.

When Medicare is primary, the following are waived:

- Copayments; and
- Care Coordination℠ notification requirements.

Since Medicare pays benefits first, the Plan will pay Benefits second as described in Section 10, *Coordination of Benefits (COB)*.

SECTION 5 - PLAN HIGHLIGHTS

The table below provides an overview of Copays that apply when you receive certain Covered Health Services, and outlines the Plan's Annual Deductible, Out-of-Pocket Maximum and Lifetime Maximum Benefit.

Plan Features	In-Network	Out-of-Network
Copays[1]		
■ Emergency Health Services – Emergency Room Facility	$50 Copay	$50 Copay
■ Emergency Health Services – Emergency Room Physician	$50 Copay	$50 Copay
■ Physician's Office Services - Primary Care Physician	$15 Copay	80% of allowed benefits after you meet the Annual Deductible
■ Physician's Office Services - Specialist	$25 Copay	80% of allowed benefits after you meet the Annual Deductible
■ Urgent Care Center Services	$20 Copay	80% of allowed benefits after you meet the Annual Deductible
Annual Deductible[2]		
■ Individual	Not Applicable	$250
■ Family (not to exceed $250 per Covered Person for Out-of-Network)	Not Applicable	$500
Annual Coinsurance and Deductible Out-of-Pocket Maximum (In-Network and Out-of-Network Out-of-Pockets Cross Apply)[2]		
■ Individual	Not Applicable	$3,000
■ Family (not to exceed $3,000 per Covered Person for Out-of-Network)	Not Applicable	$6,000

Plan Features	In-Network	Out-of-Network
Annual Copayment Out-of-Pocket Maximum[3]		
■ Individual Copay Maximum	$1,000	
■ Family Copay Maximum	$2,000	
Lifetime Maximum Benefit[4]		
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.	Unlimited	

[1]In addition to these Copays, you may be responsible for meeting the Annual Deductible for the Covered Health Services described in the chart on the following pages. With the exception of Emergency Health Services, a Copay does not apply when you visit an Out-of-Network provider.

[2]Copays do not apply toward the Annual Deductible and only apply to the Copay Out-of-Pocket Maximum. The Annual Deductible applies toward the Coinsurance and Deductible Out-of-Pocket Maximum for all Covered Health Services. In-Network and Out-of-Network Out-of-Pocket Maximums cross apply.

[3]Copays have a separate out-of-pocket maximum.

[4]Generally the following are considered to be essential benefits under the Patient Protection and Affordable Care Act: Ambulatory patient services; emergency services, hospitalization; maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment); rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

This table provides an overview of the Plan's coverage levels. For detailed descriptions of your Benefits, refer to Section 6, *Additional Coverage Details*. Some services have limits.

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	In-Network	**Out-of-Network**
Acupuncture Services (for chronic pain management only)	100% of allowed benefits after a $20 Copay	80% of allowed benefits after you meet the Annual Deductible
Allergy Care/Testing		
■ Physician's office visit	100% of allowed benefits after a $15 per visit Primary Care Physician $25 per visit Specialist	80% of allowed benefits after you meet the Annual Deductible
■ Allergy injection with no Physician's office visit	100% of allowed benefits	80% of allowed benefits after you meet the Annual Deductible
Ambulance Services (Medical Emergency and Non-Emergency) An example of Non-Emergency Ambulance would be transferring someone from one medical facility to another.	100% of allowed benefits for medical emergency 100% of allowed benefits for non-emergency	100% of allowed benefits for medical emergency 80% of allowed benefit after you meet the Annual Deductible for non-emergency
Amino Acid-Based Elemental Formula	100% of allowed benefits	80% of allowed benefits after you meet the Annual Deductible
Cancer Resource Services (CRS)[2]		
■ Hospital Inpatient Stay	100% of allowed benefits	Not Covered
Chiropractic Treatment	100% of allowed benefits after a $20 Copay	80% of allowed benefits after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	In-Network	**Out-of-Network**
Cleft Lip/Palate	100% of allowed benefits	80% of allowed benefits after you meet the Annual Deductible
Clinical Trials	Depending upon where the Covered Health Service is provided, Benefits for Clinical Trials will be the same as those stated under each Covered Health Service category in this section.	
Congenital Heart Disease (CHD) Surgeries	100% of allowed benefits	80% of allowed benefits after you meet the Annual Deductible
Dental Services - Accident Only (Copay is per visit)	100% of allowed benefits after a $25 Copay	80% of allowed benefits after you meet the Annual Deductible
Diabetes Services		
■ 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 - diabetes supplies	100% of allowed benefits	80% of allowed benefits after you meet the Annual Deductible
Durable Medical Equipment (DME)		
■ Breast Pumps	100% of allowed benefits	Not Covered
■ All other Durable Medical Equipment	100% of allowed benefits	80% of allowed benefits after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	In-Network	**Out-of-Network**
Emergency Health Services - Outpatient If you are admitted as an inpatient to an In-Network Hospital directly from the emergency room, you will not have to pay this Copay. The Benefits for an Inpatient Stay in an In-Network Hospital will apply instead.		
■ Medical Emergency (Copay is per visit)	100% of allowed benefits after a $50 Copay for Physician charges and a $50 Copay for facility charges	100% of allowed benefits after a $50 Copay for Physician charges and a $50 Copay for facility charges
■ Non-Emergency (Copay is per visit) Non-Emergency Services would be services that do not meet the definition of Medical Emergency or Emergency Services as defined in the Glossary.	50% of allowed benefits after a $50 Copay for Physician charges and a $50 Copay for facility charges	50% of allowed benefits after a $50 Copay for Physician charges and a $50 Copay for facility charges
Family Planning	Coverage level depends on covered service provided	Coverage level depends on covered service provided
Hearing Care (Copay is per visit) See Section 6, *Additional Coverage Details*, for limits	*Primary Care Physician:* 100% of allowed benefits after a $15 Copay *Specialist:* 100% of allowed benefits after a $25 Copay	80% of allowed benefits after you meet the Annual Deductible 80% of allowed benefits after you meet the Annual Deductible
Hearing Aids Up to one hearing aid per hearing impaired ear every 36 months Basic Model Only	100% of allowed benefits	100% of allowed benefits after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	In-Network	**Out-of-Network**
Home Health Care Up to 120 visits per calendar year	100% of allowed benefits	80% of allowed benefits after you meet the Annual Deductible
Hospice Care	100% of allowed benefits	80% of allowed benefits after you meet the Annual Deductible
Hospital - Inpatient Stay	100% of allowed benefits	80% of allowed benefits after you meet the Annual Deductible
Infertility Services ■ Physician's Office Services (Copay is per visit)	*Primary Care Physician:* 100% of allowed benefits after a $15 Copay *Specialist:* 100% of allowed benefits after a $25 Copay	80% of allowed benefits after you meet the Annual Deductible
■ Outpatient services received at a Hospital or Alternate Facility See Section 6, *Additional Coverage Details*, for limits	100% of allowed benefits	80% of allowed benefits after you meet the Annual Deductible
Kidney Resource Services (KRS)[3] (These Benefits are for Covered Health Services provided through KRS only)	100% of allowed benefits	Not Covered
Lab, X-Ray and Diagnostics - Outpatient	100% of allowed benefits	80% of allowed benefits after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	In-Network	**Out-of-Network**
Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	100% of allowed benefits	80% of allowed benefits after you meet the Annual Deductible
Medical Foods and Tube Feeding Supplies	100% of allowed benefits	80% of allowed benefits after you meet the Annual Deductible
Medical Supplies - Disposable See Section 6, *Additional Coverage Details* for limits	100% of allowed benefits	80% of allowed benefits after you meet the Annual Deductible
Nutritional Counseling - Preventive		
■ Primary Care Physician	100% of allowed benefits	80% of allowed benefits after you meet the Annual Deductible
■ Specialist Physician	100% of allowed benefits	80% of allowed benefits after you meet the Annual Deductible
Nutritional Counseling - Non-Preventive		
■ Primary Care Physician (Copay is per visit)	100% of allowed benefits after a $15 Copay	80% of allowed benefits after you meet the Annual Deductible
■ Specialist Physician (Copay is per visit)	100% of allowed benefits after a $25 Copay	80% of allowed benefits after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	In-Network	**Out-of-Network**
Obesity Surgery		
■ Physician's Office Services (Copay is per visit)	100% of allowed benefits after a $25 Copay	80% of allowed benefits after you meet the Annual Deductible
■ Physician Fees for Surgical and Medical Services	100% of allowed benefits	80% of allowed benefits after you meet the Annual Deductible
■ Hospital - Inpatient Stay	100% of allowed benefits	80% of allowed benefits after you meet the Annual Deductible
Ostomy Supplies	100% of allowed benefits	80% of allowed benefits after you meet the Annual Deductible
Pharmaceutical Products – Outpatient See Section 6, *Additional Coverage Details* for an explanation.	100% of allowed benefits	80% of allowed benefits after you meet the Annual Deductible
Physician Fees for Surgical and Medical Services	100% of allowed benefits	80% of allowed benefits after you meet the Annual Deductible
Physician's Office Services - Sickness and Injury		
■ Primary Care Physician (Copay is per visit)	100% of allowed benefits after a $15 Copay	80% of allowed benefits after you meet the Annual Deductible
■ Specialist Physician (Copay is per visit)	100% of allowed benefits after a $25 Copay	80% of allowed benefits after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	In-Network	**Out-of-Network**
Pregnancy – Maternity Services	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.	
Preventive Care Services		
■ Primary Care Physician	100% of allowed benefits	80% of allowed benefits after you meet the Annual Deductible
- Lab and X-ray	100% of allowed benefits	
- Well child and well adult visits	100% of allowed benefits	
■ Specialist Physician	100% of allowed benefits	80% of allowed benefits after you meet the Annual Deductible
- Lab and X-ray	100% of allowed benefits	
- Well child and well adult visits	100% of allowed benefits	
■ Routine annual gynecological exam	100% of allowed benefits	
■ Immunizations	100% of allowed benefits	
See Section 6, *Additional Coverage Details* for limits		
Private Duty Nursing – Outpatient	100% of allowed benefits	80% of allowed benefits after you meet the Annual Deductible
Prosthetic Devices	100% of allowed benefits	80% of allowed benefits after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	In-Network	**Out-of-Network**
Reconstructive Procedures		
■ Physician's Office Services (Copay is per visit)	*Primary Care Physician:* 100% of allowed benefits after a $15 Copay *Specialist:* 100% of allowed benefits after a $25 Copay	80% of allowed benefits after you meet the Annual Deductible
■ Hospital - Inpatient Stay	100% of allowed benefits	80% of allowed benefits after you meet the Annual Deductible
■ Physician Fees for Surgical and Medical Services	100% of allowed benefits	80% of allowed benefits after you meet the Annual Deductible
■ Prosthetic Devices	100% of allowed benefits	80% of allowed benefits after you meet the Annual Deductible
■ Surgery - Outpatient	100% of allowed benefits	80% of allowed benefits after you meet the Annual Deductible
Rehabilitation Services - Outpatient Therapy (Copay is per visit) See Section 6, *Additional Coverage Details*, for visit limits	*Occupational, Physical and Speech Therapy:* 100% of allowed benefits after a $25 Copay *Cardiac and Pulmonary Rehabilitation Therapy:* 100% of allowed benefits	80% of allowed benefits after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	In-Network	**Out-of-Network**
Scopic Procedures - Outpatient Diagnostic and Therapeutic	100% of allowed benefits	80% of allowed benefits after you meet the Annual Deductible
Skilled Nursing Facility ■ Acute Inpatient Rehab ■ All other Up to 180 days per calendar year	100% of allowed benefit 100% of allowed benefit	Not Covered 80% of allowed benefit after you meet the Annual Deductible
Surgery - Outpatient	100% of allowed benefits	80% of allowed benefits after you meet the Annual Deductible
Telemedicine Services	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.	
Temporomandibular Joint (TMJ) Services	100% of allowed benefits	80% of allowed benefits after you meet the Annual Deductible
Therapeutic Treatments – Outpatient See Section 6, *Additional Coverage Details* for an explanation.	100% of allowed benefits	80% of allowed benefits after you meet the Annual Deductible
Transplantation Services	100% of allowed benefits	80% of allowed benefits after you meet the Annual Deductible
Travel and Lodging **Up to 60 days per transplant** (If services rendered by a Designated Facility)	For patient and companion(s) of patient undergoing transplant procedures	

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	In-Network	**Out-of-Network**
Effective 7/1/2014 **Treatment of Gender Dysphoria**	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.	
Urgent Care Center Services (Copay is per visit)	100% of allowed benefits after a $20 Copay	80% of allowed benefits after you meet the Annual Deductible
Vision Examinations ■ Medical health of the eye - Primary Care Physician (Copay is per visit) - Pediatric – No Copayment	100% of allowed benefits after a $15 Copay	80% of allowed benefits after you meet the Annual Deductible
- Specialist Physician (Copay is per visit) - Pediatric – No Copayment	100% of allowed benefits after a $25 Copay	
■ Routine refraction eye exam every calendar year	**See Section 6, *Additional Coverage Details* for benefit maximums**	
Vision Hardware	**See Section 6, *Additional Coverage Details* for benefit maximums**	
Whole Blood and Blood Products	100% of allowed benefits	80% of allowed benefits after you meet the Deductible
Wigs	100% of allowed benefits	80% of allowed benefits after you meet the Annual Deductible

[1]You must notify Care Coordination℠, as described in Section 4, *Care Coordination℠* to receive full Benefits before receiving certain Covered Health Services. See Section 6, *Additional Coverage Details* for further information.

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	In-Network	Out-of-Network

[2]These Benefits are for Covered Health Services provided through CRS at a Designated Facility. For oncology services not provided through CRS, the Plan pays Benefits as described under *Physician's Office Services - Sickness and Injury, Physician Fees for Surgical and Medical Services*, *Hospital - Inpatient Stay*, *Surgery - Outpatient*, *Scopic Procedures - Outpatient Diagnostic and Therapeutic* Lab, *X-Ray and Diagnostics – Outpatient*, and *Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine – Outpatient*.

[3]These Benefits are for Covered Health Services provided through KRS at a Designated Facility. For kidney services not provided through KRS, the Plan pays Benefits as described under *Physician's Office Services - Sickness and Injury, Physician Fees for Surgical and Medical Services*, *Hospital - Inpatient Stay*, *Surgery - Outpatient*, *Scopic Procedures - Outpatient Diagnostic and Therapeutic* Lab, *X-Ray and Diagnostics – Outpatient*, and *Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine – Outpatient*.

SECTION 6 - ADDITIONAL COVERAGE DETAILS

What this section includes:

- Covered Health Services for which the Plan pays Benefits; and
- Covered Health Services that require you to notify Care Coordination℠ before you receive them, and any reduction in Benefits that may apply if you do not call Care Coordination℠.

This section supplements the second table in Section 5, *Plan Highlights*.

While the table provides you with benefit limitations along with Copayment, Coinsurance and Annual Deductible information for each Covered Health Service, this section includes descriptions of the Benefits. These descriptions include any additional limitations that may apply, as well as Covered Health Services for which you must call Care Coordination℠. The Covered Health Services in this section appear in the same order as they do in the table for easy reference. Services that are not covered are described in Section 8, *Exclusions*.

Acupuncture Services

The Plan pays for acupuncture services for chronic pain management provided that the service is performed in an office setting by a provider who is one of the following, either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body:

- Doctor of Medicine;
- Doctor of Osteopathy;
- Chiropractor; or
- Acupuncturist.

Covered Health for comprehensive treatment program for chronic pain.

Allergy Care

Coverage includes skin testing, Physician services and injections. No copay applies if office visit is not billed.

Ambulance Services (Medical Emergency and Non-Emergency)

The Plan covers ambulance services in a Medical Emergency and transportation provided by a licensed ambulance service to the nearest Hospital that offers Emergency Health Services. See Section 14, *Glossary* for the definition of Medical Emergency.

Ambulance service by air is covered in a Medical Emergency if ground transportation is impossible, or would put your life or health in serious jeopardy. If special circumstances exist, UnitedHealthcare may pay Benefits for Medical Emergency air transportation to a Hospital that is not the closest facility to provide Emergency Health Services.

The Plan also covers transportation provided by a licensed professional ambulance, other than air ambulance, (either ground or air ambulance, as UnitedHealthcare determines appropriate) between facilities when the transport is:

- from an Out-of-Network Hospital to an In-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.

In most cases, UnitedHealthcare will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, please remember that you must notify Care Coordination℠ as soon as possible prior to the transport. If Care Coordination℠ is not notified, you will be responsible for paying all charges and no Benefits will be paid.

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); and
- Impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length and motility of the gastrointestinal tract.

Cancer Resource Services (CRS)

The Plan pays Benefits for oncology services provided by Designated Facilities participating in the Cancer Resource Services (CRS) program. Designated Facility is defined in Section 14, *Glossary*.

For oncology services and supplies to be considered Covered Health Services, they must be provided to treat a condition that has a primary or suspected diagnosis relating to cancer. If you or a covered Dependent has cancer, you may:

- be referred to CRS by Care Coordination℠;
- call CRS toll-free at (866) 936-6002; or
- visit www.urncrs.com.

To receive Benefits for a cancer-related treatment, you are not required to visit a Designated Facility. If you receive oncology services from a facility that is not a Designated Facility, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury;
- Physician Fees for Surgical and Medical Services;

- Scopic Procedures - Outpatient Diagnostic and Therapeutic;
- Therapeutic Treatments - Outpatient;
- Hospital - Inpatient Stay; and
- Surgery - Outpatient.

To receive Benefits under the CRS program, you must contact CRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CRS program if CRS provides the proper notification to the Designated Facility provider performing the services (even if you self-refer to a provider in that In-Network).

Chiropractic Treatment

The Plan pays Benefits for chiropractic treatment when provided by a licensed chiropractor.

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.

Please remember that you must notify Care Coordination℠ as soon as reasonably possible. If Care Coordination℠ is not notified, Benefits will be reduced to 50% of Eligible Expenses.

Clinical Trials

Benefits are available for routine patient care costs incurred during participation in a qualifying clinical trial for the treatment of:

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

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

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

Routine patient care costs for qualifying clinical trials include:

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

Routine costs for clinical trials do not include:

- the Experimental or Investigational Service or item. The only exceptions to this are:
  - certain Category B devices;
  - certain promising interventions for patients with terminal illnesses; and
  - other items and services that meet specified criteria in accordance with our medical and drug policies;
- items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; and
- items and services provided by the research sponsors free of charge for any person enrolled in the trial.

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

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

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - *National Institutes of Health* (NIH). (Includes *National Cancer Institute* (NCI));
  - *Centers for Disease Control and Prevention* (CDC);
  - *Agency for Healthcare Research and Quality* (AHRQ);
  - *Centers for Medicare and Medicaid Services* (CMS);
  - a cooperative group or center of any of the entities described above or the *Department of Defense* (DOD) or the *Veterans Administration* (VA);
  - a qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants; or

- The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:

  - comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*; and
  - ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

- the study or investigation is conducted under an investigational new drug application reviewed by the *U.S. Food and Drug Administration*;
- the study or investigation is a drug trial that is exempt from having such an investigational new drug application;
- the clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (*IRBs*) before participants are enrolled in the trial. UnitedHealthcare may, at any time, request documentation about the trial; or
- the subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Plan.

Please remember that you must notify Care Coordination℠ as soon as the possibility of participation in a clinical trial arises. If Care Coordination℠ is not notified, Benefits will be reduced to 50% of Eligible Expenses.

Congenital Heart Disease (CHD) Surgeries

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 coverage, unless determined by United Resource Networks or Care Coordination℠ to be proven procedures for the involved diagnoses. Contact United Resource Networks at (888) 936-7246 or Care Coordination℠ 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, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury;
- Physician Fees for Surgical and Medical Services;
- Scopic Procedures - Outpatient Diagnostic and Therapeutic;
- Therapeutic Treatments – Outpatient;
- Hospital - Inpatient Stay; and
- Surgery - Outpatient.

Please remember that you must notify United Resource Networks or Care Coordination℠ as soon as CHD is suspected or diagnosed. If United Resource Networks or Care Coordination℠ is not notified, Benefits for Covered Health Services will be reduced to 50% of Eligible Expenses.

Dental Services - Accident Only

Dental services are covered by the Plan only when all of the following are true:

- treatment is necessary because of accidental damage;
- dental damage does not occur as a result of normal activities of daily living or extraordinary use of the teeth;
- dental services are received from a Doctor of Dental Surgery or a Doctor of Medical Dentistry; and
- the dental damage is severe enough that initial contact with a Physician or dentist occurs within 72 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

The following services are also covered by the Plan:

- dental services related to medical transplant procedures;
- initiation of immunosuppressives (medication used to reduce inflammation and suppress the immune system); and
- direct treatment of cancer or cleft palate.

Dental services for final treatment to repair the damage caused by accidental Injury must be started within three months of the accident unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care) and completed within 12 months of the accident.

The Plan pays for treatment of accidental Injury only for:

- emergency examination;

- necessary diagnostic x-rays;
- endodontic (root canal) treatment;
- temporary splinting of teeth;
- prefabricated post and core;
- simple minimal restorative procedures (fillings);
- extractions;
- post-traumatic crowns if such are the only clinically acceptable treatment; and
- replacement of lost teeth due to the Injury by implant, dentures or bridges.

Please remember that you should notify Care Coordination℠ 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. When you provide notification, Care Coordination℠ can determine whether the service is a Covered Health Service.

Diabetes Services

The Plan pays Benefits for the Covered Health Services identified below.

Covered Diabetes Services	
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Benefits include outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. These 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.
Diabetic 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;

Covered Diabetes Services	
	■ blood glucose and urine test strips; ■ alcohol swabs and alcohol wipes; ■ ketone test strips and tablets; and ■ lancets and lancet devices. Insulin pumps and blood glucose monitors are subject to all the conditions of coverage stated under *Durable Medical Equipment* in this section.

Please remember that you must notify Care Coordination℠ before obtaining any Durable Medical Equipment for the management and treatment of diabetes if the purchase, rental, repair or replacement of DME will cost more than $1,000. You must purchase or rent the DME from the vendor Care Coordination℠ identifies. If Care Coordination℠ is not notified, Benefits will be reduced to 50% of Eligible Expenses.

Durable Medical Equipment (DME)

The Plan pays for Durable Medical Equipment (DME) that is:

- ordered or provided by a Physician for outpatient use;
- used for medical purposes;
- not consumable or disposable;
- not of use to a person in the absence of a Sickness, Injury or disability;
- durable enough to withstand repeated use; and
- appropriate for use in the home.

If more than one piece of DME can meet your functional needs, you will receive Benefits only for the most Cost-Effective piece of equipment. Benefits are provided for a single unit of DME (example: one insulin pump) and for repairs of that unit. If you rent or purchase a piece of Durable Medical Equipment that exceeds this guideline, you may be responsible for any cost difference between the piece you rent or purchase and the piece UnitedHealthcare has determined is the most Cost-Effective.

Examples of DME include but are not limited to:

- equipment to administer oxygen;
- wheelchairs;
- Hospital beds;
- delivery pumps for tube feedings;
- burn garments;

- insulin pumps, blood glucose monitors and all related necessary supplies as described under *Diabetes Services* in this section;
- external cochlear devices and implants. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure. See *Hospital - Inpatient Stay*, *Rehabilitation Services - Outpatient Therapy* and *Surgery - Outpatient* in this section.
- 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.;
- shoe orthotics;
- equipment for the treatment of chronic or acute respiratory failure or conditions; and
- breast pump.

The Plan also covers tubings, nasal cannulas, connectors and masks used in connection with DME.

Note: DME is different from prosthetic devices – see *Prosthetic Devices* in this section.

Benefits are provided for the 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 calendar year.

At UnitedHealthcare's discretion, replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price. Repairs, including the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc., for necessary DME are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device. Requests for repairs may be made at any time.

Please remember that you must notify Care Coordination℠ if the purchase, rental, repair or replacement of DME will cost more than $1,000. You must purchase or rent the DME from the vendor Care Coordination℠ identifies. If Care Coordination℠ is not notified, Benefits will be reduced to 50% of Eligible Expenses.

Emergency Health Services - Outpatient

The Plan's emergency services Benefit pays for outpatient treatment at a Hospital or Alternate Facility when required to stabilize a patient or initiate treatment.

If you are admitted as an inpatient to an In-Network Hospital directly from the emergency room, you will not have to pay the Copay for Emergency Health Services. The Benefits for an Inpatient Stay in an In-Network Hospital will apply instead.

In-Network Benefits will be paid for an emergency admission to an Out-of-Network Hospital as long as Care Coordination℠ is notified within two business days of the admission or on the same day of admission if reasonably possible after you are admitted to an Out-of-Network Hospital. If you continue your stay in an Out-of-Network Hospital after the date your Physician determines that it is medically appropriate to transfer you to an In-Network Hospital, Out-of-Network Benefits will apply.

If criteria is not met for a Medical Emergency, the Plan coverage is 50% after a $50 Copay for the emergency room facility and a $50 Copay for the emergency Physician.

Please remember that you must notify Care Coordination℠ within two business days of the admission or on the same day of admission if reasonably possible if you are admitted to a Hospital as a result of a Medical Emergency. If Care Coordination℠ is not notified, Benefits for the Inpatient Hospital Stay will be reduced to 50% of Eligible Expenses.

Family Planning

Family planning services including examinations, insertion and removal of IUDs, Depo-provera, Norplant, or prescriptions for birth control methods and, when medically appropriate, genetic counseling. (One reversal of voluntary sterilization is covered per lifetime.)

Bilateral vasectomy and tubal ligation, in accordance with established medical practice, are covered.

Elective abortions performed within the first trimester of pregnancy are covered. Termination of Pregnancy for medical appropriateness, which is defined as documented fetal abnormalities and/or endangerment of the life of the mother if the pregnancy were completed, is covered.

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; and
- hearing aids which are required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness).

One hearing aid is covered for each impaired ear every 36 months.

The basic model hearing aid will not require prior authorization. If a member elects a hearing aid that is above the basic model, they will have to pay the difference of the basic model and the upgrade.

Coverage is provided for basic model hearing aids only if 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 basic model hearing aid only that is purchased as a result of a written recommendation by a licensed audiologist. Benefits are provided for the basic model hearing aid and for charges for associated fitting and testing.

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 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 Deductible, Copayment or Coinsurance payments.

- 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 Deductible, Copayment or Coinsurance payments.

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; and
- 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.

Care Coordination℠ 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.

Any combination of In-Network Benefits and Out-of-Network Benefits is limited to 120 visits per calendar 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.

Please remember that you must notify Care Coordination℠ five business days before receiving services or as soon as reasonably possible. If Care Coordination℠ is not notified, Benefits will be reduced to 50% of Eligible Expenses.

Hospice Care

Hospice care is an integrated program recommended by a Physician which provides comfort and support services for the terminally ill. Hospice care can be provided on an inpatient or outpatient basis and includes physical, psychological, social and spiritual care for the terminally ill person, and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a Hospital.

Please remember that you must notify Care Coordination℠ five business days before receiving services. If Care Coordination℠ is not notified, Benefits will be reduced to 50% of Eligible Expenses.

Hospital - Inpatient Stay

Hospital Benefits are available for:

- non-Physician services and supplies received during an Inpatient Stay;
- room and board in a Semi-private Room (a room with two or more beds); and
- Physician services for anesthesiologists, emergency room Physicians, consulting Physicians, pathologists and radiologists.

The Plan will pay the difference in cost between a Semi-private Room and a private room only if a private room is necessary according to generally accepted medical practice.

Benefits for an Inpatient Stay in a Hospital are available only when the Inpatient Stay is necessary to prevent, diagnose or treat a Sickness or Injury. Benefits for other Hospital-based Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Benefits for emergency admissions and admissions of less than 24 hours are described under *Emergency Health Services* and *Surgery - Outpatient, Scopic Procedures - Diagnostic and Therapeutic Services*, and *Therapeutic Treatments - Outpatient*, respectively.

Please remember that you must notify Care Coordination℠ as follows:

- for elective admissions: five business days before admission or as soon as reasonably possible; or
- for emergency admissions (also termed non-elective admissions): within two business days, or as soon as is reasonably possible.

If Care Coordination℠ is not notified, Benefits will be reduced to 50% of Eligible Expenses.

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;
- 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. Artificial Insemination is covered for a maximum of three (3) cycles per Covered Person's lifetime.

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);
    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 EOC. 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 UnitedHealthcare. 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 UnitedHealthcare the Covered Person will need to submit a claim form. Upon request the pharmacy will provide you with the proper proof 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.

Any combination of In-Network Benefits and Out-of-Network Benefits for IVF services is 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.

Please remember that you must notify Care Coordination℠ as soon as the possibility of the need for infertility services arises. If Care Coordination℠ is not notified, Benefits will be reduced to 50% of Eligible Expenses.

Kidney Resource Services (KRS)

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 14, *Glossary*.

In order to receive Benefits under this program, KRS must provide the proper notification to the In-Network provider performing the services. This is true even if you self-refer to an In-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 Care Coordination℠; or
- call KRS toll-free at (888) 936-7246 and select the KRS prompt.

To receive Benefits related to ESRD and chronic kidney disease, you are not required to visit a Designated Facility. If you receive services from a facility that is not a Designated Facility, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury;
- Physician Fees for Surgical and Medical Services;
- Scopic Procedures - Outpatient Diagnostic and Therapeutic;
- Therapeutic Treatments - Outpatient;
- Hospital - Inpatient Stay; and
- Surgery - Outpatient.

To receive Benefits under the KRS program, you must contact KRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the KRS program if KRS provides the proper notification to the Designated Facility provider performing the services (even if you self-refer to a provider in that Network).

Lab, X-Ray and Diagnostics - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility include, but are not limited to:

- lab and radiology/x-ray; and
- mammography.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment; and

- Physician services for anesthesiologists, pathologists and radiologists.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*. Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services* in this section.

Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment; and
- Physician services for anesthesiologists, pathologists and radiologists.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

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.

Medical Supplies - Disposable

The Plan pays Benefits for medical supplies and accessories which are necessary for the effective use of covered equipment (except those listed as exclusions in Section 8, *Exclusions*). The Plan covers the following medical supplies when skilled nursing is involved in wound care in the Covered Person's home setting:

- surgical dressing and burn garments for wound care;
- disposable supplies necessary for the effective use of covered DME items as described under *Durable Medical Equipment (DME)* earlier in this section including urinary catheters and urological supplies;
- supplies for renal dialysis equipment and machines; and
- compression stockings.

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;
- 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.

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 cardiopulmonary condition, sleep apnea or diabetes.

Benefits are available for obesity surgery services that meet the definition of a Covered Health Service, as defined in Section 14, *Glossary* and are not Experimental or Investigational or Unproven Services.

Please remember that you must notify Care Coordination[SM] as soon as the possibility of obesity surgery arises. If Care Coordination[SM] is not notified, Benefits will be reduced to 50% of Eligible Expenses.

Ostomy Supplies

Benefits for ostomy supplies are limited to:

- pouches, face plates and belts;
- irrigation sleeves, bags and catheters; and
- skin barriers.

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 UnitedHealthcare), 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.

Physician Fees for Surgical and Medical Services

The Plan pays Physician fees for surgical procedures and other medical care received from a Physician in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility, 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 - Sickness and Injury* in this section.

Physician's Office Services - Sickness and Injury

Benefits are paid by the Plan for Covered Health Services received in a Primary or Specialist Physician's office for the evaluation and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is free-standing, located in a clinic or located in a Hospital.

Benefits under this section include services for Injury or Sickness related to the eye. Benefits for preventive services are described under *Preventive Care* in this section. Benefits for preventive hearing care are described under *Hearing Care* in this section.

When a test is performed or a sample is drawn in the Physician's office and then sent outside the Physician's office for analysis or testing, Benefits for lab, radiology/x-rays and other diagnostic services that are performed outside the Physician's office are described in *Lab, X-ray and Diagnostics - Outpatient*.

Please Note
Your Physician does not have a copy of your EOC, and is not responsible for knowing or communicating your Benefits.

Pregnancy - 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. Benefits include those of a certified nurse-midwife or pediatric nurse practitioner.

The Plan will pay Benefits for an Inpatient Stay of at least:

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

These are federally mandated requirements under the Newborns' and Mothers' Health Protection Act of 1996 which apply to this Plan. The Hospital or other provider is not required to get authorization for the time periods stated above. Authorizations are required for longer lengths of stay. If the mother agrees, the attending Physician may discharge the mother and/or the newborn child earlier than these minimum timeframes. In the event of such a shorter stay, the plan will provide coverage for at least one home care visit as described under *Home Health Care* in this section. If the mother and newborn child remain in the Hospital for at least as long as the minimum inpatient confinement periods shown above, a single home visit will be provided if prescribed by the attending Physician as described under *Home Health Care* in this section.

In addition, when a mother is required to remain hospitalized after childbirth for medical reasons and the mother requests that the newborn remain in the Hospital, the Plan will pay the cost of the additional hospitalization for the newborn for up to 4 days as required by state law.

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

Newborn Care

The Plan pays Benefits for circumcision, including circumcision performed by a mohel recognized under the laws of Judaism.

Please remember that you must notify Care Coordination℠ as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be longer than the timeframes indicated above. If Care Coordination℠ is not notified, Benefits for the extended stay will be reduced to 50% of Eligible Expenses.

Healthy moms and babies
The Plan provides a special prenatal program to help during Pregnancy. Participation is voluntary and free of charge. See Section 7, *Resources to Help you Stay Healthy*, for details.

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-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 pumps.

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 In-Network DME provider.

Covered Health Services for preventive care include:

Covered Preventive Care Services	
Well Child Care	■ 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); ■ services for hereditary and metabolic newborn screening and follow-up visits from birth to four weeks of age including visits

Covered Preventive Care Services	
	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; and ■ 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 calendar year.
Well Adult Care	■ adult Physical exams and related lab work for ages twenty-two (22) and older. ■ one flu shot per calendar 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 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. "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	■ annual routine OB-GYN exam ■ screening mammography include: - a baseline mammogram for women 35 to 39 years of age;

Covered Preventive Care Services	
	- an annual mammogram for women age 40 or older; ■ 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; or - you are receiving long-term glucocorticoid (steroid) therapy; or - you have hyperparathyroidism; or - 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;

Covered Preventive Care Services	
	■ 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 Chlamydia trachomatis; ■ 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.

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 family. This includes nursing services provided on a home-care basis, whether the service is skilled or non-skilled independent nursing.

Please remember that you must notify Care Coordination℠ five business days before receiving services or as soon as reasonably possible. If Care Coordination℠ is not notified, Benefits will be reduced to 50% of Eligible Expenses.

Prosthetic Devices

Benefits are paid by the Plan for prosthetic devices and appliances that replace a limb or body part, or help an impaired limb or body part work. Examples include, but are not limited to:

- artificial arms, legs, feet and hands;
- artificial face, eyes, ears and noses;
- speech aid prosthetics and tracheo-esophageal voice prosthetics; and
- breast prosthesis following mastectomy as required by the Women's Health and Cancer Rights Act of 1998, including mastectomy bras and lymphedema stockings for the arm.

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.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the most cost-effective prosthetic device that meets the minimum specifications for your needs. The device must be ordered or provided either by a Physician, or under a Physician's direction. If you purchase a prosthetic device that exceeds these minimum specifications, the Plan may pay only the amount that would have paid for the prosthetic that meets the minimum specifications, and you may be responsible for paying any difference in cost.

Benefits are provided for the replacement of a prosthetic device if, upon review, the replacement is deemed needed.

At UnitedHealthcare's discretion, prosthetic devices may be covered for damage beyond repair with normal wear and tear or when repair costs are less than the cost of replacement. Replacement of artificial limbs or any part of such devices may be covered when the condition of the device or part requires repairs that cost more than the cost of a replacement device or part.

Note: Prosthetic devices are different from DME - see *Durable Medical Equipment (DME)* in this section.

Please remember that you must notify Care Coordination℠ if the purchase, rental, repair or replacement of prosthetic device will cost more than $1,000. If Care Coordination℠ is not notified, Benefits will be reduced to 50% of Eligible Expenses.

Reconstructive Procedures

Reconstructive Procedures are services performed when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function for an organ or body part. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Improving or restoring physiologic function means that the organ or body part is made to work better. An example of a Reconstructive Procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored.

Benefits for Reconstructive Procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Replacement of an existing breast implant is covered by the Plan if the initial breast implant followed mastectomy. 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 UnitedHealthcare at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

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.

There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. Cosmetic procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. A good example is upper eyelid surgery. At times, this procedure will be done to improve vision, which is considered a Reconstructive Procedure. In other cases, improvement in appearance is the primary intended purpose, which is considered a Cosmetic Procedure. This Plan does not provide Benefits for Cosmetic Procedures, as defined in Section 14, *Glossary*.

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 remember that you must notify Care Coordination℠ five business days before undergoing a Reconstructive Procedure. When you provide notification, Care Coordination℠ can determine whether the service is considered reconstructive or cosmetic. Cosmetic Procedures are always excluded from coverage.

Rehabilitation Services - Outpatient Therapy

The Plan provides short-term outpatient rehabilitation services for the following types of therapy:

- physical therapy;
- occupational therapy;
- speech therapy;
- post-cochlear implant aural therapy;
- pulmonary rehabilitation; and

- cardiac rehabilitation.

For all rehabilitation services, a licensed therapy provider, under the direction of a Physician, must perform the services.

The Plan will pay Benefits for speech therapy only when the speech impediment or dysfunction results from Injury, Sickness, stroke, cancer, autism spectrum disorders or a Congenital Anomaly, or is needed following the placement of a cochlear implant.

Benefits are limited to:

- 50 visits per calendar year for physical, occupational and speech therapy combined;
- 20 visits per calendar year for pulmonary rehabilitation therapy; and
- 36 visits within a 12 week period per event for cardiac rehabilitation therapy.

These visit limits apply to In-Network Benefits and Out-of-Network Benefits combined.

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.

Benefits for Habilitative Services for all other Covered Persons are subject to the limits as stated in the benefit section.

To notify Care Coordination℠ of a physical, occupational or speech therapy course of treatment, call (800) 955-8063.

Unlimited visits for speech therapy are available for a diagnosis of brain Injury.

Please remember that you must notify Care Coordination℠ as follows:
- after the sixth visit for physical therapy;
- after the sixth visit for occupational therapy; and
- for all speech therapy visits.

You must notify Care Coordination℠ five business days before receiving services or as soon as reasonably possible. If Care Coordination℠ is not notified, Benefits will be reduced to 50% of Eligible Expenses.

Scopic Procedures - Outpatient Diagnostic and Therapeutic

The Plan pays for diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

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

Benefits under this section include:

- the facility charge and the charge for supplies and equipment; and

- Physician services for anesthesiologists, pathologists and radiologists.

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, and hysteroscopy.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Facility services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility are covered by the Plan. Benefits include:

- non-Physician services and supplies received during the Inpatient Stay;
- room and board in a Semi-private Room (a room with two or more beds); and
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits are available when skilled nursing and/or Inpatient Rehabilitation Facility services are needed on a daily basis. Benefits are also available in a Skilled Nursing Facility or Inpatient Rehabilitation Facility for treatment of a Sickness or Injury that would have otherwise required an Inpatient Stay in a Hospital.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

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

Benefits are available only if:

- the initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a Cost Effective alternative to an Inpatient Stay in a Hospital; and
- you will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when:

- it is delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient;
- it is ordered by a Physician;
- it is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair; and
- it requires clinical training in order to be delivered safely and effectively.

You are expected to improve to a predictable level of recovery. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

Note: The Plan does not pay Benefits for Custodial Care or Domiciliary Care, even if ordered by a Physician, as defined in Section 14, *Glossary*.

Any combination of In-Network Benefits and Out-of-Network Benefits is limited to 180 days per calendar year. The plan does not cover Out-of-Network Acute Inpatient Rehab.

Please remember that you must notify Care Coordination℠ as follows:
- for elective admissions: five business days before admission; or
- for emergency admissions (also termed non-elective admissions): within two business days, or as soon as is reasonably possible.

If Care Coordination℠ is not notified, Benefits will be reduced to 50% of Eligible Expenses.

The plan does not cover Out-of-Network Acute Inpatient Rehab.

Surgery - Outpatient

The Plan pays for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment;
- certain surgical scopic procedures (examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy); and
- Physician services for anesthesiologists, pathologists and radiologists.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

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.

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.

Temporomandibular Joint (TMJ) Services

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:

- there is clearly demonstrated radiographic evidence of significant joint abnormality;
- non-surgical treatment has failed to adequately resolve the symptoms; and
- 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.

Please remember that you must notify Care Coordination℠ five business days before receiving services or as soon as reasonably possible. If Care Coordination℠ is not notified, Benefits will be reduced to 50% of Eligible Expenses.

Therapeutic Treatments - Outpatient

The Plan pays Benefits for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including but not limited to dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals 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.

Benefits under this section include:

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

Services.

Please remember that you must notify Care Coordination℠ five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as reasonably possible. If Care Coordination℠ is not notified, Benefits will be reduced to 50% of Eligible Expenses.

Transplantation Services

Inpatient facility services (including evaluation for transplant, organ procurement and donor searches) for transplantation procedures must be ordered by a provider. 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;
- 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. You are not required to notify United Resource Networks or Care Coordination℠ of a cornea transplant nor is the cornea transplant required to be performed at a Designated Facility.

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

The Plan has specific guidelines regarding Benefits for transplant services. Contact United Resource Networks at (888) 936-7246 or Care Coordination℠ at the telephone number on your ID card for information about these guidelines.

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with transplant services received at a Designated Facility.

To receive Benefits for a transplant, you are not required to visit a Designated Facility. If you receive services from a facility that is not a Designated Facility, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury;
- Physician Fees for Surgical and Medical Services;
- Scopic Procedures - Outpatient Diagnostic and Therapeutic;
- Therapeutic Treatments - Outpatient;
- Hospital - Inpatient Stay; and
- Surgery - Outpatient.

Support in the event of serious illness
If you or a covered family member has cancer or needs an organ or bone marrow transplant, UnitedHealthcare can put you in touch with quality treatment centers around the country.

Please remember that you must notify United Resource Networks or Care Coordination℠ as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If United Resource Networks or Care Coordination℠ is not notified, Benefits will be reduced to 50% of Eligible Expenses.

Travel and Lodging

United Resource Networks or Care Coordination℠ will assist the patient and family with travel and lodging arrangements related to transplant services.

For travel and lodging services to be covered, the patient must be receiving services at a Designated Facility through United Resource Networks.

The Plan covers expenses for travel and lodging for the patient, provided he or she is not covered by Medicare, and a companion 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 procedure or necessary post-discharge follow-up;
- Eligible Expenses for lodging for the patient (while not a Hospital inpatient) and one companion; or
- if the patient is an enrolled Dependent minor child, the transportation expenses of two companions will be covered.

Travel and lodging expenses are only available if the recipient lives more than 50 miles from the Designated Facility. UnitedHealthcare must receive valid receipts for such charges before you will be reimbursed. Examples of travel expenses may include:

- airfare at coach rate;
- taxi or ground transportation; or
- mileage reimbursement at the IRS rate for the most direct route between the patient's home and the Designated Facility.

A maximum of 60 days per transplant, per Covered Person applies for all travel and lodging expenses reimbursed under this Plan in connection with all transplant procedures.

Effective 7/1/2014

Treatment of Gender Dysphoria

The Plan pays Benefits for the treatment of gender dysphoria as follows:

- Outpatient psychotherapy/mental health services for gender dysphoria and associated co-morbid psychiatric diagnoses. The benefits are the same as any other outpatient mental health service in the Program.
- Continuous hormone replacement therapy. The benefits are the same as any other eligible drug in the Program. Note the following clarifications:
  - Hormones injected by a medical provider (for example during an office visit) are covered by the medical plan. Benefits for these injections vary depending on the plan design.
  - Oral and self-injected hormones from a pharmacy are not covered under the medical plan. Refer to the Benefit Guide for specific prescription drug product coverage and exclusion terms. They are covered under the separately provided prescription drug plan, if enrolled.
- **Outpatient laboratory testing to monitor continuous hormone therapy**. The benefits are the same as any other outpatient diagnostic service in the Program.
- **Gender reassignment surgery.** Medically necessary gender reassignment procedures are covered, as follows. The procedures identified in this paragraph and any combination of procedures within each type of transition – *male-to-female transition*: orchiectomy, penectomy, clitoroplasty, labiaplasty, vaginoplasty, thyroid chondroplasty; *female-to-male transition:* vaginectomy, hysterectomy, mastectomy, salpingooophorectomy, ovariectomy, metoidioplasty, phalloplasty, scrotoplasty, placement of testicular prostheses; *either:* urethroplasty – are considered medically necessary for treatment of gender dysphoria when *all* of the following criteria are met:
  - The individual is at least 18 years of age; and
  - The individual has capacity to make fully informed decisions and consent for treatment; and
  - The individual has been diagnosed with gender dysphoria and exhibits all of the following:
    - The desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatment; and

- The gender dysphoria (pre and post diagnosis) has been present persistently for at least two years; and
- The gender dysphoria is not a symptom of another mental disorder; and
- The gender dysphoria causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

- For individuals without a medical contraindication or not otherwise unable to take hormones, the individual has undergone a minimum of 12 months of continuous hormonal therapy when recommended by a mental health professional and provided under the supervision of a physician. (Hormonal therapy is not required as a prerequisite to a mastectomy.); and
- Documentation that the individual has completed a minimum of 12 months of successful continuous, substantially full time real-life experience in their new gender, across a wide range of life experiences and events that may occur throughout the year. (The real-life experience is not required as a perquisite to a mastectomy, augmentation mammoplasty, thyroid chondroplasty, hysterectomy, salpingo-oophorectomy, or orchiectomy.); and
- Regular participation in psychotherapy and/or ongoing clinical treatment throughout the real-life experience may be required when recommended by a treating medical or behavioral health practitioner or when medically necessary; and
- If the individual has significant medical or mental health issues present, they must be reasonably well controlled. If the individual is diagnosed with severe psychiatric disorders and impaired reality testing (e.g., psychotic episodes, bipolar disorder, dissociative identity disorder, borderline personality disorder), an effort must be made to improve these conditions with psychotropic medications and/or psychotherapy before surgery is contemplated; and
- *****Two referrals from qualified mental health professionals who have independently assessed the individual. If the first referral is from the individual's psychotherapist, the second referral should be from a person who has only had an evaluative role with the individual. Two separate letters, or one letter signed by both (e.g., if practicing within the same clinic) are required.

*****At least one of the professionals submitting a letter must have a doctoral degree (Ph.D., M.D., Ed.D., D.Sc., D.S.W., or Psy.D) and be capable of adequately evaluating co-morbid psychiatric conditions. One letter is sufficient if signed by two providers, one of whom has met the doctoral degree specifications, in addition to the specifications set forth above. One letter signed by an appropriate provider is sufficient to support benefits for a mastectomy. The medical documentation should include the start date of living full time in the new gender, when applicable.

- **Augmentation mammoplasty.** Provided the criteria above for gender reassignment surgery have been satisfied, augmentation mammoplasty (including breast prosthesis if necessary) may be covered for male-to-female transgender individuals if the Physician prescribing hormones and the treating surgeon have documented that, after undergoing hormone treatment for 12 months, breast size continues to cause clinically significant distress in social, occupational, or other areas of functioning.

Note on gender specific services for post-transition transgender persons

Gender-specific services may be medically necessary for transgender persons appropriate to their anatomy. Examples include:

- Breast cancer screening may be medically necessary for female to male transgender persons who have not undergone a mastectomy;
- Prostate cancer screening may be medically necessary for male to female transgender individuals who have retained their prostate.

Notes:

For individuals considering hysterectomy/salpingo-oophorectomy, orchiectomy, vaginectomy or vaginoplasty procedures a total of 12 months of continuous hormonal sex reassignment is required.

Cryopreservation, storage, and thawing of reproductive tissue (i.e., oocytes, ovaries, testicular tissue) and the charged associated therewith (e.g., office, hospital, ultrasounds, laboratory tests, etc.) are not covered.

Urgent Care Center Services

The Plan provides Benefits for services, including professional services, received at an Urgent Care Center, as defined in Section 14, *Glossary*. When Urgent Care services are provided in a Physician's office, the Plan pays Benefits as described under *Physician's Office Services - Sickness and Injury* earlier in this section.

Vision Examinations and Vision Hardware (Adult)

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); and
- one routine vision exam, including refraction, to detect vision impairment by a provider in the provider's office every calendar 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; or
- aphakic - aspheric up to $162.

Frames are covered once per year up to $45.

Contact lenses are covered 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.

Vision Examinations and Vision Hardware (Pediatric)

Dependents under the age of 19, no dollar limits or frequency limits will apply to vision benefits.

- Vision Exam (Routine)
  In-network -100% of the allowed benefits
  Out-of-network - 100% of the eligible expenses
  No coinsurance, copay, or deductible should be applied
  If out-of-network provider is used there may be member responsibility
- Vision Exam (Medical)
  In-network -100% of the allowed benefits.
  Out-of-network - 80% of the eligible expenses after the deductible
- Frames, Lenses and Contacts (Contacts in lieu of frames and lenses)
  In-network -100% of the allowed benefits.
  Out-of-network - 80% of the eligible expenses after the deductible

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.

Wigs

The Plan pays Benefits for wigs and other scalp hair prosthesis only for loss of hair resulting from hair loss due to chemotherapy or radiation for cancer.

SECTION 7 - RESOURCES TO HELP YOU STAY HEALTHY

What this section includes:
Health and well-being resources available to you:

- **www.myuhc.com**;
- Optum® NurseLine℠;
- Live Nurse Chat;
- Activation Campaigns;
- Healthy Pregnancy Program; and
- UnitedHealth Premium℠ Program.

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; and
- 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. UnitedHealthcare 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.

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; and
- 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 Copays and Annual Deductibles;
- view and print all of your Explanation of Benefits (EOBs) online; and
- 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;
- exercise;
- weight management;
- stress;
- smoking cessation;
- diabetes; and
- 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; or
- any other health related topic.

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:

- weight control;
- parenting;
- heart disease;
- relationships; and
- 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; and
- 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 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, UnitedHealthcare may send you and your covered Dependents materials focused on the following topics:

- your health care experience;
- your health and wellness; and
- value for your health care dollar.

UnitedHealth Premium℠ Program

UnitedHealthcare 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; and
- 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.

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.

SECTION 8 - EXCLUSIONS: WHAT THE MEDICAL PLAN WILL NOT COVER

What this section includes:

- Services, supplies and treatments that are not Covered Health Services, except as may be specifically provided for in Section 6, *Additional Coverage Details*.

The Plan does not pay Benefits for the following services, treatments or supplies even if they are recommended or prescribed by a provider or are the only available treatment for your condition.

When Benefits are limited within any of the Covered Health Services categories described in Section 6, *Additional Coverage Details*, those limits are stated in the corresponding Covered Health Service category in Section 5, *Plan Highlights*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in Section 5, *Plan Highlights*. Please review all limits carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed these benefit limits.

Please note that in listing services or examples, when the EOC says "this includes," or "including but not limiting to", it is not UnitedHealthcare's intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the EOC specifically states that the list "is limited to."

Alternative Treatments

1. Acupressure;
2. aromatherapy;
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 (holistic tissue massage); and
6. art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the National Center for Complimentary and Alternative Medicine (NCCAM) 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 6, *Additional Coverage Details*.

Dental

1. Dental care, except as identified under *Dental Services - Accident Only* in Section 6, *Additional Coverage Details*;

   Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment

of dental care resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded.

2. diagnosis or treatment of or related to the teeth, jawbones or gums. Examples include:

   - extractions (including wisdom teeth);
   - restoration and replacement of teeth;
   - medical or surgical treatments of dental conditions; and
   - services to improve dental clinical outcomes.

   This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services – Accident Only* in Section 6, *Additional Coverage Details*.

3. dental implants, bone grafts, and other implant-related procedures;

   This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services – Accident Only* in Section 6, *Additional Coverage Details*.

4. dental braces (orthodontics);

5. dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia except as described under *Dental Services – Accident Only* in Section 6, *Additional Coverage Details*; and

   This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan, as identified in Section 6, *Additional Coverage Details*.

6. treatment of congenitally missing (when the cells responsible for the formation of the tooth are absent from birth), malpositioned or supernumerary (extra) teeth, even if part of a Congenital Anomaly such as cleft lip or cleft palate.

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 6, *Additional Coverage Details*.

3. the following items are excluded, even if prescribed by a Physician:

   - blood pressure cuff/monitor;
   - enuresis alarm;
   - home coagulation testing equipment;
   - non-wearable external defibrillator;
   - trusses; and
   - 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; and

7. oral appliances for snoring.

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 UnitedHealthcare, 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; and

5. over the counter drugs and treatments.

Experimental or Investigational or Unproven Services

Experimental or Investigational Services or Unproven Services, unless the Plan has agreed to cover them as defined in Section 14, *Glossary*.

This exclusion applies even if Experimental or Investigational Services or Unproven Services, treatments, devices or pharmacological regimens are the only available treatment options for your 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 6, *Additional Coverage Details*.

Foot Care

1. Routine foot care, 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 6, *Additional Coverage Details*. Routine foot care services that are not covered include:

   - cutting or removal of corns and calluses;
   - nail trimming or cutting; and
   - debriding (removal of dead skin or underlying tissue);

2. hygienic and preventive maintenance foot care. Examples include:

   - cleaning and soaking the feet; or
   - applying skin creams in order to maintain skin tone; and other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot;

   This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.

3. treatment of flat feet;

4. shoe inserts;

5. arch supports;

6. shoes (standard or custom), lifts and wedges; and

7. shoe orthotics in excess of the limit described under *Durable Medical Equipment (DME)* in Section 6, *Additional Coverage Details*.

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; and
   - 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 6, *Additional Coverage Details*;
   - disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Diabetes Services* in Section 6, *Additional Coverage Details*; or

- diabetic supplies for which Benefits are provided as described under *Diabetes Services* in Section 6, *Additional Coverage Details*.

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; and

5. deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover or other items that are not specifically identified in Section 6, *Additional Coverage Details*.

Mental Health/Substance Abuse

1. Services for the treatment of mental illness or mental health conditions and substance abuse services and chemical dependency services that the State of Maryland has elected to provide through a separate benefit Plan; and

2. treatment provided in connection with involuntary commitments, police detentions and other similar arrangements.

Nutrition

1. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other 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 6, *Additional Coverage Details*;

3. food of any kind, except as described under *Amino Acid-Based Elemental Formula* and *Medical Foods and Tube Feeding Supplies* in Section 6, *Additional Coverage Details*. 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; and
   - other dietary and electrolyte supplements; and

4. health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

Personal Care, Comfort or Convenience

1. Television;

2. telephone;

3. beauty/barber service;

4. guest service; and

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 6;
   - car seats;
   - chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners;
   - dehumidifiers and humidifiers;
   - ergonomically correct chairs;
   - electric scooters;
   - 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;
   - strollers;
   - safety equipment;
   - vehicle modifications such as van lifts; and
   - video players.

Physical Appearance

1. Cosmetic Procedures, as defined in Section 14, *Glossary*, are excluded from coverage. 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; and
- replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure;

2. breast reduction surgery that is determined to be a Cosmetic Procedure.

   This exclusion does not apply to breast reduction surgery which the Claims Administrator determines is requested to treat a physiologic functional impairment or to coverage required by the Women's Health and Cancer Right's Act of 1998 for which Benefits are described under *Reconstructive Procedures* in Section 6, *Additional Coverage Details*;

3. physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, health club memberships and programs, spa treatments, and diversion or general motivation;

4. weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity;

5. wigs regardless of the reason for the hair loss except for hair loss due to chemotherapy or radiation for cancer; and

6. treatment of benign gynecomastia (abnormal breast enlargement in males).

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 6, *Additional Coverage Details*;

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 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 6, *Additional Coverage Details*;

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) Services* in Section 6, *Additional Coverage Details*;

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; and

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

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; and

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.

Reproduction

1. 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 6, *Additional Coverage Details*;

2. surrogate parenting, donor eggs, donor sperm and host uterus;

3. the reversal of voluntary sterilization in excess of one per Covered Person per lifetime;

4. artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes;

5. elective surgical, non-surgical or drug induced Pregnancy termination after the first trimester;

6. services provided by a doula (labor aide); and

7. parenting, pre-natal or birthing classes.

Services Provided under Another Plan

Services for which coverage is available:

1. under another plan, except for Eligible Expenses payable as described in Section 10, *Coordination of Benefits (COB)*;

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; and

4. for treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably accessible.

Transplants

1. Health services for organ and tissue transplants, except as identified under *Transplantation Services* in Section 6*, Additional Coverage Details* unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines;

2. mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available); and

3. donor costs for organ or tissue transplantation to another person (these costs may be payable through the recipient's benefit plan).

Travel

Travel or transportation expenses, even if ordered by a Physician, except as identified under *Travel and Lodging* in Section 6, *Additional Coverage Details*. Additional travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at the Plan's discretion.

Treatment of Gender Dysphoria

1. Nipple/areola reconstruction, except in connection with a covered augmentation mammoplasty or mastectomy.

2. Breast enlargement procedures, except in connection with a covered augmentation mammoplasty.

3. Brow lift.

4. Cheek implants.

5. Chin/nose implants.

6. Collagen injections.

7. Electrolysis.
8. Facial bone reconstruction.
9. Face/forehead lift.
10. Hair removal/hairplasty/hair transplantation.
11. Jaw shortening/sculpturing/facial bone reduction.
12. Lip reduction/enhancement.
13. Liposuction.
14. Neck tightening.
15. Reversal of genital or breast surgery or reversal of surgery to revise secondary sex characteristics.
16. Voice modification surgery.
17. Voice therapy/voice lessons.
18. Rhinoplasty.
19. Removal of redundant skin, except in connection with a covered surgery.
20. Replacement of tissue expander with permanent prosthesis testicular insertion, except as a component of a covered placement of a testicular prosthesis.
21. Second stage phalloplasty.
22. Surgical correction of hydraulic abnormality of inflatable (multi-component) prosthesis including pump and/or cylinders and/or reservoir.
23. Testicular prostheses, except as a component of a covered placement of a testicular prosthesis (subsequent replacement or correction of such prosthesis subject to rules and limitations applicable to all prosthetic devices).
24. Blepharoplasty.
25. Penile prosthesis (non-inflatable/inflatable), except in connection with a covered phalloplasty (implantation of the prosthesis shall not be considered a second stage phalloplasty) in a female-to-male transition (subsequent replacement or correction of such prosthesis subject to rules and limitations applicable to all prosthetic devices).
26. Testicular expanders, except as a component of a covered placement of a testicular prosthesis.
27. Laryngoplasty.

28. Mastopexy.

29. Abdominoplasty.

Types of Care

1. Custodial Care as defined in Section 14, *Glossary;*

2. Domiciliary Care, as defined in Section 14, *Glossary;*

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; and

8. work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision

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 Hardware* in Section 6, *Additional Coverage Details*;

3. eye exercise therapy; and

4. surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.

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; or
   - record processing.

3. charges prohibited by federal anti-kickback or self-referral statutes;

4. diagnostic tests that are:

   - delivered in a setting other than a Physician's office or health care facility; and
   - 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 14, *Glossary*;
   - 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; or
   - that exceed Eligible Expenses or any specified limitation in this EOC;
   - for which an Out-of-Network provider waives the Copay, Annual Deductible or Coinsurance 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; or
   - required to obtain or maintain a license of any type.

SECTION 9 - CLAIMS PROCEDURES

What this section includes:

- How In-Network and Out-of-Network claims work; and
- What to do if your claim is denied, in whole or in part.

In-Network Benefits

In general, if you receive Covered Health Services from an In-Network provider, UnitedHealthcare will pay the Physician or facility directly. If an In-Network provider bills you for any Covered Health Service other than your Copay or Coinsurance, please contact the provider or call UnitedHealthcare at the phone number on your ID card for assistance.

Keep in mind, you are responsible for paying any Copay or Coinsurance owed to an In-Network provider at the time of service, or when you receive a bill from the provider.

Out-of-Network Benefits

If you receive a bill for Covered Health Services from an Out-of-Network provider, you (or the provider if they prefer) must send the bill to UnitedHealthcare for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to UnitedHealthcare at the address on the back of your ID card.

If Your Provider Does Not File Your Claim

You can obtain a claim form by visiting **www.myuhc.com**, calling the toll-free number on your ID card or contacting your Agency Benefit Coordinator or the Employee Benefits Division. If you do not have a claim form, simply attach a brief letter of explanation to the bill, and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

- your name and address;
- the patient's name, age and relationship to the Participant;
- the number as shown on your ID card;
- the name, address and tax identification number of the provider of the service(s);
- a diagnosis from the Physician;
- the date of service; and
- an itemized bill from the provider that includes:
  - the Current Procedural Terminology (CPT) codes;
  - a description of, and the charge for, each service;
  - the date the Sickness or Injury began; and
  - 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 and address of the other carrier(s).

Failure to provide all the information listed above may delay any reimbursement that may be due you.

After UnitedHealthcare has processed your claim, you will receive payment for Benefits that the Plan allows. It is your responsibility to pay the Out-of-Network provider the charges you incurred, including any difference between what you were billed and what the Plan paid.

UnitedHealthcare will pay Benefits to you unless:

- the provider notifies UnitedHealthcare that you have provided signed authorization to assign Benefits directly to that provider; or
- you make a written request for the Out-of-Network provider to be paid directly at the time you submit your claim.

UnitedHealthcare will only pay Benefits to you or, with written authorization by you, your provider, and not to a third party, even if your provider has assigned Benefits to that third party.

Health Statements

Each month in which UnitedHealthcare processes at least one claim for you or a covered Dependent, you will receive a Health Statement in the mail. Health Statements make it easy for you to manage your family's medical costs by providing claims information in easy-to-understand terms.

If you would rather track claims for yourself and your covered Dependents online, you may do so at **www.myuhc.com**. You may also elect to discontinue receipt of paper Health Statements by making the appropriate selection on this site.

Explanation of Benefits (EOB)

You may request that UnitedHealthcare send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. If you would like paper copies of the EOBs, you may call the toll-free number on your ID card to request them. You can also view and print all of your EOBs online at **www.myuhc.com**. See Section 14, *Glossary* for the definition of Explanation of Benefits.

Important - Timely Filing of Claims
All claim forms must be submitted within 12 months after the date of service. Otherwise, the Plan will not pay any Benefits for that Eligible Expense, or Benefits will be reduced, as determined by UnitedHealthcare. This 12-month requirement 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.

Claim Denials and Appeals

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 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; and
- 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.

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.

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.

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
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 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
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.

SECTION 10 - COORDINATION OF BENEFITS (COB)

What this section includes:

- How your Benefits under this Plan coordinate with other medical plans;
- How coverage is affected if you become eligible for Medicare; and
- Procedures in the event the Plan overpays 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.

Don't forget to update your Dependents' Medical Coverage Information
Avoid delays on your Dependent claims by updating your Dependent's medical coverage information. Just log on to **www.myuhc.com** or call the toll-free number on your ID card to update your COB information. You will need the name of your Dependent's other medical coverage, along with the policy number.

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 a Participant 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
  - the Spouse of the parent not having custody of the child;
- plans for active Participants pay before plans covering laid-off or retired Participants;
- 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 allowed benefits 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.

The following examples illustrate how the Plan determines which plan pays first and which plan pays second.

Determining Primary and Secondary Plan – Examples
1) Let's say you and your Spouse both have family medical coverage through your respective employers. You are unwell and go to see a Physician. Since you're covered as a Participant under this Plan, and as a Dependent under your Spouse's plan, this Plan will pay Benefits for the Physician's office visit first.
2) Again, let's say you and your Spouse both have family medical coverage through your respective employers. You take your Dependent child to see a Physician. This Plan will look at your birthday and your Spouse's birthday to determine which plan pays first. If you were born on June 11 and your Spouse was born on May 30, your Spouse's plan will pay first.

When This Plan is Secondary to any Plan other than Medicare

When 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; or
- if this Plan would have paid more than the primary plan paid, the Plan will pay the difference less any applicable Deductible, Coinsurance and Copay requirements of the Plan.

You will be responsible for any Coinsurance, Deductible and/or Copay payments as part of the COB payment.

When This Plan is Secondary to Medicare

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

- When Benefit for covered services are paid by Medicare primary, UnitedHealthcare will not duplicate those payments; and
- 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 Allowed benefit 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 allowed benefit is the primary plan's In-Network rate. If the primary plan bases its reimbursement on reasonable and customary charges, the allowed benefit is the primary plan's reasonable and customary charge. If both the primary plan and this Plan do not have a contracted rate, the allowed benefit will be the greater of the two plans' reasonable and customary charges.

When the provider is an In-Network provider for both the primary plan and this Plan, the allowed benefit is the primary plan's In-Network rate. When the provider is an In-Network provider for the primary plan and an Out-of-Network provider for this Plan, the allowed benefit is the primary plan's In-Network rate. When the provider is an Out-of-Network provider for the primary plan and an In-Network provider for this Plan, the allowed benefit is the reasonable and customary charges allowed by the primary plan. When the provider is an Out-of-Network provider for both the primary plan and this Plan, the allowed benefit is the greater of the two Plans' reasonable and customary charges.

What is an allowed benefit?
For purposes of COB, an allowed benefit 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 Allowed benefit When This Plan is Secondary

If this Plan is secondary to Medicare, the Medicare approved amount is the allowed benefit, 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 allowed benefit. Medicare payments, combined with Plan Benefits, will not exceed 100% of the total allowed benefit.

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.

When Medicare is primary, the following are waived:

- Copayments and
- Care Coordination℠ notification requirements.

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.

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.

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

The refund equals the amount the State of Maryland paid in excess of the amount that should have paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help the State of Maryland 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 State of Maryland 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 State of Maryland may have other rights in addition to the right to reduce future Benefits.

SECTION 11 - SUBROGATION AND REIMBURSEMENT

What this section includes:

- How your Benefits are impacted if you suffer a Sickness or Injury caused by a third party.

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

Right of Recovery

The Plan has the right to recover benefits it has paid on you or your Dependent's behalf that were:

- made in error;
- due to a mistake in fact;
- advanced during the time period of meeting the calendar year Deductible; or
- advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.

Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

If the Plan provides a Benefit for you or your Dependent that exceeds the amount that should have been paid, the Plan will:

- require that the overpayment be returned when requested or
- reduce a future benefit payment for you or your Dependent by the amount of the overpayment.

If the Plan provides an advancement of benefits to you or your Dependent during the time period of the Deductible and/or meeting the Out-of-Pocket Maximum for the calendar year, the Plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover Benefits it has advanced by:

- submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan and
- conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

Right to Subrogation

The right to subrogation means the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for Benefits that the Plan has paid that are related to the Sickness or Injury for which a third party is considered responsible. Subrogation applies when the Plan has paid on your behalf 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 from any third party, 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;
- any insurer or other indemnifier of any person or entity who caused the Sickness, Injury or damages;
- the State of Maryland in workers' compensation cases; or
- 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; or
  - any other insurance carrier or third party administrator.

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.
- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any

determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule shall limit the Plan's subrogation and reimbursement rights.

- Benefits paid by the Plan may also be considered to be Benefits advanced.
- 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;
  - notifying the plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable;
  - responding to requests for information about any accident or injuries;
  - appearing at medical examinations and legal proceedings, such as depositions or hearings; and
  - 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 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.
- Upon the Plan's request, 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, at its option, take necessary and appropriate action to assert its rights under this section, including filing suit in your name, which does not obligate it in any way to pay you part of any recovery the Plan might obtain.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- In case of your wrongful death or survival claim, 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.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

Subrogation – Example
Suppose you are injured in a car accident that is not your fault, and you receive Benefits under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those Benefits.

SECTION 12 - WHEN COVERAGE ENDS

What this section includes:

- Circumstances that cause coverage to end;
- Conversion from a group policy to an individual policy; and
- How to continue coverage after it ends.

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.

Your coverage under the Plan will end on the earliest of:

- the 15th of the month if your employment with the Group ends 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 15th 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 eligible 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 eligible Dependent turns age 26.

Other Events Ending Your Coverage

The Plan will provide prior written notice to you that your coverage will end on the date identified in the notice if:

- you commit an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact including, but not limited to, false information relating to another person's eligibility or status as a Dependent; or
- you commit an act of physical or verbal abuse that imposes a threat to the State of Maryland's staff, UnitedHealthcare's staff, a provider or another Covered Person.

Note: The State of Maryland has the right to demand that you pay back Benefits the State of Maryland paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.

Coverage for a Disabled Child

If an unmarried enrolled Dependent child with a mental or physical disability reaches an age when coverage would otherwise end, the Plan will continue to cover the child, as long as:

- the child is unable to be self-supporting due to a mental or physical handicap or disability;
- the child depends mainly on you for support;
- you provide to the State of Maryland proof of the child's incapacity and dependency within 60 days of the date coverage would have otherwise ended because the child reached a certain age; and
- you provide proof, upon the State of Maryland's request, that the child continues to meet these conditions.

The proof might include medical examinations at the State of Maryland's expense. However, you will not be asked for this information more than once a year. If you do not supply such proof within 60 days, the Plan will no longer pay Benefits for that child.

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

Continuing Coverage Through COBRA

If you lose your Plan coverage, you may have the right to extend it under the Consolidated Budget Reconciliation Act of 1985 (COBRA), as defined in Section 14, *Glossary*.

Continuation coverage under COBRA is available only to Plans that are subject to the terms of COBRA. You can contact your Plan Administrator to determine if the State of Maryland is subject to the provisions of COBRA.

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 were 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; or

- a Participant's former Spouse or same-sex Domestic Partner.

Qualifying Events for Continuation Coverage under COBRA

The following table outlines situations in which you may elect to continue coverage under COBRA for yourself and your Dependents, and the maximum length of time you can receive continued coverage. These situations are considered qualifying events.

If Coverage Ends Because of the Following Qualifying Events:	You May Elect COBRA:		
	For Yourself	For Your Spouse/ Same-Sex Domestic Partner	For Your Child(ren)
Your work hours are reduced	18 months	18 months	18 months
Your employment terminates for any reason (other than gross misconduct)	18 months	18 months	18 months
You or your family member become eligible for Social Security disability benefits at any time within the first 60 days of losing coverage[1]	29 months	29 months	29 months
You die	N/A	36 months	36 months
You divorce (or legally separate) or dissolve your same-sex domestic partnership[2]	N/A	36 months – domestic partner Unlimited - spouse	36 months
Your child is no longer an eligible family member (e.g., reaches the maximum age limit)	N/A	N/A	36 months
You become entitled to Medicare	N/A	See table on next page	See table on next page

[1]Subject to the following conditions: (i) notice of the disability must be provided within the latest of 60 days after a). the determination of the disability, b). the date of the qualifying event, c). the date the Qualified Beneficiary would lose coverage under the Plan, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months over the original 18 months; and (iii) if the Qualified Beneficiary entitled to the 11 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 11 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

If Coverage Ends Because of the Following Qualifying Events:	You May Elect COBRA:		
	For Yourself	For Your Spouse/ Same-Sex Domestic Partner	For Your Child(ren)

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.

[2]A dependent spouse may also be eligible for COBRA if he or she is terminated from coverage by the employee spouse in anticipation of divorce or separation. If this occurs, the dependent spouse would be entitled to the same COBRA rights as a divorced spouse.

How Your Medicare Eligibility Affects Dependent COBRA Coverage

The table below outlines how your Dependents' COBRA coverage is impacted if you become entitled to Medicare.

If Dependent Coverage Ends When:	You May Elect COBRA Dependent Coverage For Up To:
You become entitled to Medicare and don't experience any additional qualifying events	18 months
You become entitled to Medicare, after which you experience a second qualifying event* before the initial 18-month period expires	36 months
You experience a qualifying event*, after which you become entitled to Medicare before the initial 18-month period expires; and, if absent this initial qualifying event, your Medicare entitlement would have resulted in loss of Dependent coverage under the Plan	36 months

* Your work hours are reduced or your employment is terminated for reasons other than gross misconduct.

Getting Started

You will be notified by mail if you become eligible for COBRA coverage as a result of a reduction in work hours or termination of employment. The notification will give you instructions for electing COBRA coverage and advise you of the monthly cost. Your monthly cost is the full cost, including both Participant and Employer costs, plus a 2% administrative fee or other cost as permitted by law.

You will have up to 60 days from the date you receive notification or 60 days from the date your coverage ends to elect COBRA coverage, whichever is later. You will then have an

additional 45 days to pay the cost of your COBRA coverage, retroactive to the date your Plan coverage ended.

During the 60-day election period, the Plan will, only in response to a request from a provider, inform that provider of your right to elect COBRA coverage, retroactive to the date your COBRA eligibility began.

While you are a participant in the medical Plan under COBRA, you have the right to change your coverage election:

- during Open Enrollment; and
- following a change in family status, as described under *Changing Your Coverage* in Section 2*, Introduction*.

Notification Requirements

If your covered Dependents lose coverage due to divorce, legal separation, dissolution of a same-sex domestic partnership, or loss of Dependent status, you or your Dependents must notify the Plan Administrator within 60 days of the latest of:

- the date of the divorce, legal separation, dissolution of a same-sex domestic partnership or an enrolled Dependent's loss of eligibility as an enrolled Dependent;
- the date your enrolled Dependent would lose coverage under the Plan; or
- the date on which you or your enrolled Dependent are informed of your obligation to provide notice and the procedures for providing such notice.

You or your Dependents must also notify the Plan Administrator when a qualifying event occurs that will extend continuation coverage.

If you or your Dependents fail 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 you are continuing coverage under federal law, you must notify the Plan Administrator within 60 days of the birth or adoption of a child.

Once you have notified the Plan Administrator, you will then be notified by mail of your election rights under COBRA.

Notification Requirements for Disability Determination

If you extend your COBRA coverage beyond 18 months because you are eligible for disability benefits from Social Security, you must provide your Agency Benefit Coordinator or the Employee Benefits Division with notice of the Social Security Administration's determination within 60 days after you receive that determination, and before the end of your initial 18-month continuation period.

The notice requirements will be satisfied by providing written notice to the Plan Administrator. The contents of the notice must be such that the Plan Administrator is able to determine the covered Employee and qualified beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event occurred.

Trade Act of 2002

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 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.

When COBRA Ends

COBRA coverage will end before the maximum continuation period shown above if:

- you or your covered Dependent becomes covered under another group medical plan, as long as the other plan doesn't limit your coverage due to a preexisting condition; or if the other plan does exclude coverage due to your preexisting condition, your COBRA benefits would end when the exclusion period ends;
- you or your covered Dependent becomes entitled to, and enrolls in, Medicare after electing COBRA;
- the first required premium is not paid within 45 days;
- any other monthly premium is not paid within 30 days of its due date;
- the entire Plan ends; or
- coverage would otherwise terminate under the Plan as described in the beginning of this section.

Note: 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 in this section, whichever is earlier.

Conversion from a Group Plan to an Individual Plan

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

- you are no longer eligible as a Participant or enrolled Dependent; or
- continuation coverage ends.

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

In addition, you may not be eligible for conversion coverage if you are:

- age 65 or older;
- covered under or eligible for coverage under Medicare (title XVIII as amended); or
- covered under or eligible for any group, individual, prepayment, government, or other plan or program which would result in overinsurance if conversion coverage was issued.

You must submit your first application and payment to UnitedHealthcare or its designated insurance company within 31 days after coverage ends under this Plan. UnitedHealthcare or its designated insurance company will issue conversion coverage according to the terms and conditions in effect at the time you apply. Conversion coverage may be substantially different from coverage provided under this Plan. Even though you may be eligible for conversion coverage, UnitedHealthcare does not offer conversion products in certain states. When a conversion product is not available, the conversion coverage may be provided by a state sponsored risk pool.

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 Plan coverage for the Participant and the Participant's Dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, 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 the 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, 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.

SECTION 13 - OTHER IMPORTANT INFORMATION

What this section includes:

- Qualified Medical Child Support Orders (QMCSOs);
- Your relationship with UnitedHealthcare and the State of Maryland;
- Relationships with providers;
- Interpretation of Benefits;
- Information and records;
- Incentives to providers and you;
- The future of the Plan; and
- How to access the official Plan documents.

Qualified Medical Child Support Orders (QMCSOs)

A qualified medical child support order (QMCSO) is a judgment, decree or order issued by a court or appropriate state agency that requires a child to be covered for medical benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement.

If the Plan receives a medical child support order for your child that instructs the Plan to cover the child, the Plan Administrator will review it to determine if it meets the requirements for a QMCSO. If it determines that it does, your child will be enrolled in the Plan as your Dependent, and the Plan will be required to pay Benefits as directed by the order.

You may obtain, without charge, a copy of the procedures governing QMCSOs from the Plan Administrator.

Note: A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

Your Relationship with UnitedHealthcare and the State of Maryland

In order to make choices about your health care coverage and treatment, the State of Maryland believes that it is important for you to understand how UnitedHealthcare interacts with the Plan Sponsor's benefit Plan and how it may affect you. UnitedHealthcare helps administer the Plan Sponsor's benefit Plan in which you are enrolled. UnitedHealthcare does not provide medical services or make treatment decisions. This means:

- the State of Maryland and UnitedHealthcare do not decide what care you need or will receive. You and your Physician make those decisions;
- UnitedHealthcare communicates to you decisions about whether the Plan will cover or pay for the health care that you may receive (the Plan pays for Covered Health Services, which are more fully described in this EOC); and

- the Plan may not pay for all treatments you or your Physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

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

Relationship with Providers

The relationships between the State of Maryland, UnitedHealthcare and In-Network providers are solely contractual relationships between independent contractors. In-Network providers are not the State of Maryland's agents or employees, nor are they agents or employees of UnitedHealthcare. The State of Maryland and any of its employees are not agents or employees of Network providers, nor are UnitedHealthcare and any of its employees agents or employees of Network providers.

The State of Maryland and UnitedHealthcare do not provide health care services or supplies, nor do they practice medicine. Instead, the State of Maryland and UnitedHealthcare arranges for health care providers to participate in a Network and pay Benefits. In-Network providers are independent practitioners who run their own offices and facilities. UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not the State of Maryland's employees nor are they employees of UnitedHealthcare. The State of Maryland and UnitedHealthcare do not have any other relationship with In-Network providers such as principal-agent or joint venture. The State of Maryland and UnitedHealthcare are not liable for any act or omission of any provider.

UnitedHealthcare 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.

The State of Maryland and the Plan Administrator are solely responsible for:

- enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage);
- the timely payment of Benefits; and
- 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. Your provider is solely responsible for the quality of the services provided to you. You:

- are responsible for choosing your own provider;

- are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any Annual Deductible and any amount that exceeds Eligible Expenses;
- are responsible for paying, directly to your provider, the cost of any non-Covered Health Service;
- must decide if any provider treating you is right for you (this includes In-Network providers you choose and providers to whom you have been referred); and
- must decide with your provider what care you should receive.

Interpretation of Benefits

The State of Maryland and UnitedHealthcare have the sole and exclusive discretion to:

- interpret Benefits under the Plan;
- interpret the other terms, conditions, limitations and exclusions of the Plan, including this EOC and any Riders and/or Amendments; and
- make factual determinations related to the Plan and its Benefits.

The State of Maryland and UnitedHealthcare may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan.

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

Information and Records

The State of Maryland and UnitedHealthcare may use your individually identifiable health information to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. The State of Maryland and UnitedHealthcare may request additional information from you to decide your claim for Benefits. The State of Maryland and UnitedHealthcare will keep this information confidential. The State of Maryland and UnitedHealthcare may also use your de-identified data for commercial purposes, including research, as permitted by law.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish the State of Maryland and UnitedHealthcare with all information or copies of records relating to the services provided to you. The State of Maryland and UnitedHealthcare 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. The State of Maryland and UnitedHealthcare agree that such information and records will be considered confidential.

The State of Maryland and UnitedHealthcare 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 the State of Maryland is required to do by law or regulation. During and after the term of the Plan, the State of Maryland and UnitedHealthcare and its related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your medical records or billing statements the State of Maryland recommends 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 UnitedHealthcare, they also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, the State of Maryland and UnitedHealthcare will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Our designees have the same rights to this information as does the Plan Administrator.

Incentives to You

Sometimes you may be offered coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but the State of Maryland recommends that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. You may call the number on the back of your ID card if you have any questions.

Rebates and Other Payments

The State of Maryland and UnitedHealthcare may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet your Annual Deductible. The State of Maryland and UnitedHealthcare do not pass these rebates on to you, nor are they applied to your Annual Deductible or taken into account in determining your Copays or Coinsurance.

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.

Future of the Plan

Although the Group expects to continue the Plan indefinitely, it reserves the right to discontinue, alter or modify the Plan in whole or in part, at any time and for any reason, at its sole determination.

The Group's decision to terminate or amend a Plan may be due to changes in federal or state laws governing employee benefits, the requirements of the Internal Revenue Code, or any other reason. A plan change may transfer plan assets and debts to another plan or split a

plan into two or more parts. If the Group does change or terminate a plan, it may decide to set up a different plan providing similar or different benefits.

If this Plan is terminated, Covered Persons will not have the right to any other Benefits from the Plan, other than for those claims incurred prior to the date of termination, or as otherwise provided under the Plan. In addition, if the Plan is amended, Covered Persons may be subject to altered coverage and Benefits.

The amount and form of any final benefit you receive will depend on any Plan document or contract provisions affecting the Plan and Group decisions. After all Benefits have been paid and other requirements of the law have been met, certain remaining Plan assets will be turned over to the Group and others as may be required by any applicable law.

Plan Document

This Evidence of Coverage (EOC) represents an overview of your Benefits. In the event there is a discrepancy between the EOC and the official plan document, the plan document will govern. A copy of the plan document is available for your inspection during regular business hours in the office of the Plan Administrator. You (or your personal representative) may obtain a copy of this document by written request to the Plan Administrator, for a nominal charge.

SECTION 14 - GLOSSARY

What this section includes:
- Definitions of terms used throughout this EOC.

Many of the terms used throughout this EOC may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how Benefits are paid. This section defines terms used throughout this EOC, but it does not describe the Benefits provided by the Plan.

Addendum – any attached written description of additional or revised provisions to the Plan. The benefits and exclusions of this EOC and any amendments thereto shall apply to the Addendum except that in the case of any conflict between the Addendum and EOC and/or Amendments to the EOC, the Addendum shall be controlling.

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; or
- rehabilitative, laboratory, diagnostic or therapeutic services.

Amendment – any attached written description of additional or alternative provisions to the Plan. Amendments are effective only when distributed by the Plan Sponsor or the Plan Administrator. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that the amendment is specifically changing.

Annual Deductible (or Deductible) – the amount you must pay for Covered Health Services in a calendar year before the Plan will begin paying Out-of-Network Benefits in that calendar year. The Deductible is shown in the first table in Section 5*, Plan Highlights*. Any amount you pay for medical expenses in the last three months of the previous calendar year, that is applied to the previous Deductible, will be carried over and applied to the current Deductible. This carry-over feature applies to the individual and family Deductible.

Assisted Reproductive Technology (ART) – the comprehensive term for procedures involving the manipulation of human reproductive materials (such as sperm, eggs, and/or embryos) to achieve Pregnancy. Examples of such procedures are:

- in vitro fertilization (IVF);
- gamete intrafallopian transfer (GIFT);
- pronuclear stage tubal transfer (PROST);
- tubal embryo transfer (TET); and
- zygote intrafallopian transfer (ZIFT).

Please note that Benefits are not available for GIFT and ZIFT procedures.

Benefits – Plan payments for Covered Health Services, subject to the terms and conditions of the Plan and any Addendums and/or 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 (CRS) – a program administered by UnitedHealthcare or its affiliates made available to you by the State of Maryland. The CRS program provides:

- specialized consulting services to Participants and enrolled Dependents with cancer;
- access to cancer centers with expertise in treating specific forms of cancer – even the most rare and complex conditions; and
- guidance for the patient on the prescribed plan of care and the potential side effects of radiation and chemotherapy.

Care Coordination℠ – programs provided by UnitedHealthcare that focus on prevention, education, and closing the gaps in care designed to encourage an efficient system of care for you and your covered Dependents.

CHD – see Congenital Heart Disease (CHD).

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 – UnitedHealthcare (also known as United HealthCare Services, Inc.) and its affiliates, who provide certain claim administration services for the Plan.

Clinical Trial – a scientific study designed to identify new health services that improve health outcomes. In a Clinical Trial, two or more treatments are compared to each other and the patient is not allowed to choose which treatment will be received.

COBRA – see Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Coinsurance – the percentage of Eligible Expenses you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works*.

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

Congenital Heart Disease (CHD) – any structural heart problem or abnormality that has been present since birth. Congenital heart defects may:

- be passed from a parent to a child (inherited);

- develop in the fetus of a woman who has an infection or is exposed to radiation or other toxic substances during her Pregnancy; or
- have no known cause.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) – a federal law that requires employers to offer continued health insurance coverage to certain employees and their dependents whose group health insurance has been terminated.

Copayment (or Copay) – the set dollar amount you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works*.

Cosmetic Procedures – procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator. Reshaping a nose with a prominent bump is a good example of a Cosmetic Procedure because appearance would be improved, but there would be no improvement in function like breathing.

Cost-Effective – the least expensive equipment that performs the necessary function. This term applies to Durable Medical Equipment and prosthetic devices.

Covered Health Services – those health services, including services, supplies or Pharmaceutical Products, which the State of Maryland determines to be:

- provided for the purpose of preventing, diagnosing or treating Sickness, Injury, mental illness, substance abuse, or their symptoms;
- consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below;
- not provided for the convenience of the Covered Person, Physician, facility or any other person;
- included in Sections 5 and 6, Plan Highlights and Additional Coverage Details;
- provided to a Covered Person who meets the Plan's eligibility requirements, as described under *Eligibility* in Section 2, *Introduction*; and
- not identified in Section 8, *Exclusions*.

In applying the above definition, "scientific evidence" and "prevailing medical standards" have the following meanings:

- "scientific evidence" means the results of controlled Clinical Trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community; and
- "prevailing medical standards and clinical guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.

The Claims Administrator maintains clinical protocols that describe the scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. You can access these clinical protocols (as revised from time to time) on **www.myuhc.com** or by calling the number on the back of your ID card. This information is available to Physicians and other health care professionals on UnitedHealthcareOnline.

Covered Person – either the Participant or an enrolled Dependent only while enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this EOC are references to a Covered Person.

CRS – see Cancer Resource Services (CRS).

Custodial Care – services that do not require special skills or training and that:

- provide assistance in activities of daily living (including but not limited to feeding, dressing, bathing, ostomy care, incontinence care, checking of routine vital signs, transferring and ambulating);
- 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.

Deductible – see Annual Deductible.

Dependent – an individual who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. 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 with the Claims Administrator or with an organization contracting on behalf of the Plan, to provide Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within your geographic area.

To be considered a Designated Facility, a facility must meet certain standards of excellence and have a proven track record of treating specific conditions.

DME – see Durable Medical Equipment (DME).

Domestic Partner – 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:

- 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.

Domiciliary Care – living arrangements designed to meet the needs of people who cannot live independently but do not require Skilled Nursing Facility services.

Durable Medical Equipment (DME) – medical equipment that is all of the following:

- used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms;
- not disposable;
- not of use to a person in the absence of a Sickness, Injury or their symptoms;
- durable enough to withstand repeated use;
- not implantable within the body; and
- appropriate for use, and primarily used, within the home.

Eligible Expenses – charges for Covered Health Services that are provided while the Plan is in effect, determined as follows:

For:	Eligible Expenses are Based On:
In-Network Benefits	Contracted rates with the provider
Out-of-Network Benefits	■ one of the following: - for Covered Health Services other than Pharmaceutical Products, selected data resources which, in the judgment of the Claims Administrator, represent competitive fees in that geographic area; - for Covered Health Services that are Pharmaceutical Products, 100% of the amount that the *Centers for Medicare and Medicaid Services (CMS)* would have paid under the Medicare program for the drug determined by either: - reference to available *CMS* schedules; or - methods similar to those used by *CMS*; - fee(s) that are negotiated with the provider; or ■ a fee schedule that the Claims Administrator develops.

For:	Eligible Expenses are Based On:
	These provisions do not apply if you receive Covered Health Services from an Out-of-Network provider in an emergency. In that case, Eligible Expenses are the amounts billed by the provider, unless the Claims Administrator negotiates lower rates.

For certain Covered Health Services, you are required to pay a percentage of Eligible Expenses in the form of a Copay and/or Coinsurance.

Eligible Expenses are subject to the Claims Administrator's reimbursement policy guidelines. You may request a copy of the guidelines related to your claim from the Claims Administrator.

Employee Benefits Division – Division within the State of Maryland that administers the State of Maryland Employee and Retiree Health and Welfare Benefits Program.

Employer – the State of Maryland.

EOB – see Explanation of Benefits (EOB).

Experimental or Investigational Services – medical, surgical, diagnostic, psychiatric, mental health, substance use disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time UnitedHealthcare makes a determination 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;
- subject to review and approval by any institutional review board for the proposed use (Devices which are FDA approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational); or
- 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.

Exceptions:

- Clinical trials for which Benefits are available as described under Clinical Trials in Section 6, *Additional Coverage Details*.
- If you are not a participant in a qualifying Clinical Trial as described under Section 6, *Additional Coverage Details,* and have a Sickness or condition that is likely to cause death within one year of the request for treatment, UnitedHealthcare may, at its discretion,

consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, UnitedHealthcare must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Explanation of Benefits (EOB) – a statement provided by UnitedHealthcare to you, your Physician, or another health care professional that explains:

- the Benefits provided (if any);
- the allowable reimbursement amounts;
- Deductibles;
- Coinsurance;
- any other reductions taken;
- the net amount paid by the Plan; and
- the reason(s) why the service or supply was not covered by the Plan.

Gender Dysphoria - A disorder characterized by the following diagnostic criteria:

- a strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex);
- persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex;
- the disturbance is not concurrent with a physical intersex condition; and
- the disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Group – the State of Maryland.

Health Statement(s) – a single, integrated statement that summarizes EOB information by providing detailed content on account balances and claim activity.

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, which is:

- primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of sick or injured 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 Skilled Nursing Facility, convalescent home or similar institution.

In-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 its affiliate to participate in the In-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 the Claims Administrator through common ownership or control with the Claims Administrator or with the Claims Administrator's 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 an In-Network provider for only some products. In this case, the provider will be an In-Network provider for the Covered Health Services and products included in the participation agreement, and an Out-of-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

In-Network Benefits - description of how Benefits are paid for Covered Health Services provided by In-Network provider. Refer to Section 5, *Plan Highlights* for details about how In-Network Benefits apply.

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.

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 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.

Intermittent Care - skilled nursing care that is provided or needed either:

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

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

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; and

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

Medicaid – a federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

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:

- placing the patient's health in jeopardy;
- serious impairment of bodily functions; or
- serious dysfunction of any bodily organ or part.

If a Primary Care 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.

Open Enrollment – the period of time, determined by the State of Maryland, during which eligible Participants may enroll themselves and their Dependents under the Plan. The State of Maryland determines the period of time that is the Open Enrollment period.

Orthotics – devices that straighten or change the shape of a body part, including but not limited to cranial banding and some types of braces.

Out-of-Network Benefits - description of how Benefits are paid for Covered Health Services provided by Out-of-Network providers. Refer to Section 5, *Plan Highlights* for details about how Out-of-Network Benefits apply.

Out-of-Pocket Maximum – the maximum amount you pay every calendar year. Refer to Section 5, *Plan Highlights* for the Out-of-Pocket Maximum amount. See Section 3, *How the Plan Works* for a description of how the Out-of-Pocket Maximum works.

Participant – a Participant of the Employer who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. A Participant must live and/or work in the United States.

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 or Doctor of Osteopathy who is properly licensed and qualified by law.

Please note: Any podiatrist, dentist, psychologist, chiropractor, optometrist or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that a provider is described as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

Plan – The State of Maryland Medical Plan.

Plan Administrator – the State of Maryland or its designee.

Plan Sponsor – the State of Maryland.

Pregnancy – includes prenatal care, postnatal care, childbirth, and any complications associated with Pregnancy.

Pre-implantation Genetic Diagnosis (PGD) – a screening test typically performed in conjunction with in vitro fertilization (IVF) in which one or two cells are removed from an embryo to be screened for genetic abnormalities.

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

Reconstructive Procedure – a procedure performed to address a physical impairment where the expected outcome is restored or improved function. The primary purpose of a Reconstructive Procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not changed or improved physical appearance. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure.

Retired Employee – an Employee who retires while covered under the Plan.

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 EOC does not include mental illness or substance abuse, regardless of the cause or origin of the mental illness or substance abuse.

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

- they are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient;
- a Physician orders them;
- they are not delivered for the purpose of assisting with activities of daily living, including, but not limited to, dressing, feeding, bathing or transferring from a bed to a chair;
- they require clinical training in order to be delivered safely and effectively; and
- they are not Custodial Care, as defined in this section.

Skilled Nursing Facility – a nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility that is part of a Hospital is considered a Skilled Nursing Facility for purposes of the Plan.

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

Spouse – an individual to whom you are legally married or a Domestic Partner as defined in this section.

UnitedHealth Premium Program – a program that identifies In-Network Physicians or facilities that have been designated as a UnitedHealth Premium Program Physician or facility for certain medical conditions.

To be designated as a UnitedHealth Premium provider, Physicians and facilities must meet program criteria. The fact that a Physician or facility is an In-Network Physician or facility does not mean that it is a UnitedHealth Premium Program Physician or facility.

Unproven Services – health services, including medications that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature:

- Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received.
- Well-conducted cohort studies are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

UnitedHealthcare has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, UnitedHealthcare issues medical and drug policies that describe the clinical evidence available with respect to specific health care

services. These medical and drug policies are subject to change without prior notice. You can view these policies at **www.myuhc.com**.

Please note: If you have a life threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), UnitedHealthcare may, at its discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, UnitedHealthcare must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the National Institutes of Health.

Urgent Care – treatment of an unexpected Sickness or Injury that is not life-threatening but requires outpatient medical care that cannot be postponed. An urgent situation requires prompt medical attention to avoid complications and unnecessary suffering, such as high fever, a skin rash, or an ear infection.

Urgent Care Center – a facility that provides Urgent Care services, as previously defined in this section. In general, Urgent Care Centers:

- do not require an appointment;
- are open outside of normal business hours, so you can get medical attention for minor illnesses that occur at night or on weekends; and
- provide an alternative if you need immediate medical attention, but your Physician cannot see you right away.

SECTION 15 - IMPORTANT ADMINISTRATIVE INFORMATION

What this section includes:
- Plan administrative information.

This section includes information on the administration of the medical Plan. While you may not need this information for your day-to-day participation, it is information you may find important.

Additional Plan Description

Claims Administrator: The company which provides certain administrative services for the Plan Benefits described in this Evidence 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 Evidence of Coverage, the Plan Sponsor also has selected a provider network established by United HealthCare Services, Inc. The named fiduciary of 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.

ADDENDUM - UNITEDHEALTH ALLIES

Introduction

This Addendum to the Evidence 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 Evidence of Coverage (EOC). See Section 14, *Glossary* in the EOC.

> *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 Evidence of Coverage (see Section 5, *Plan Highlights*) 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.

Discounts through UnitedHealth Allies are available to you and your Dependents as defined in the Evidence of Coverage in Section 14, *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.

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.

ATTACHMENT I - HEALTH CARE REFORM NOTICES

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.