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**SUMMARY PLAN DESCRIPTION**

**The Maryland National Capital Park and Planning Commission
‍Indemnity Complement**

**Effective:** January 1, 2024

**Group Number:** 712973



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# SECTION 1 - WELCOME

Quick Reference Box

* Member services, claim inquiries, Personal Health Support‍‍‍ and Mental Health/Substance-Related and Addictive Disorders Administrator: 1-800-603-4190.
* Claims submittal address: UnitedHealthcare - Claims, P.O. Box 74800, Atlanta, GA 30374-0800.
* Online assistance: **www.myuhc.com**.

The Maryland National Capital Park and Planning Commission is pleased to provide you with this Summary Plan Description (SPD), which describes the health Benefits available to you and your covered family members‍. It includes summaries of:

* Who is eligible.
* Services that are covered, called Covered Health Services.
* Services that are not covered, called Exclusions and Limitations.
* How Benefits are paid.
* Your rights and responsibilities under the Plan.

This SPD is designed to meet your information needs‍*‍*. It supersedes any previous printed or electronic SPD for this Plan.

The Maryland National Capital Park and Planning Commission 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 subject to any collective bargaining agreements between the Employer and various unions, if applicable. This SPD 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 Maryland National Capital Park and Planning Commission is solely responsible for paying Benefits described in this SPD.

Please read this SPD thoroughly to learn how the Plan works. If you have questions contact your local Human Resources‍‍ department or call the number on your ID card.

How To Use This SPD

* Read the entire SPD, and share it with your family. Then keep it in a safe place for future reference.
* Many of the sections of this SPD are related to other sections. You may not have all the information you need by reading just one section.
* You can find copies of your SPD and any future amendments‍**‍** or request printed copies by contacting Human Resources‍‍.
* Capitalized words in the SPD have special meanings and are defined in Section 13, Glossary.
* If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in Section 13, *Glossary*.
* The Maryland National Capital Park and Planning Commission is also referred to as Company.
* If there is a conflict between this SPD and any benefit summaries (other than Summaries of Material Modifications) provided to you, this SPD 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.
* When you can make coverage changes under the Plan.

Eligibility

You are eligible to enroll in the Plan if you are a regular full-time employee who is scheduled to work at least ‍ hours per week or a person who retires while covered under the Plan.

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

* Your Spouse, as defined in Section 13, *Glossary.*
* Your or your Spouse's child who is under age 26, including a natural child, stepchild, 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 age 26 or over who is or becomes disabled and dependent upon you. A child is no longer eligible as a Dependent on the last day of the ‍month following the date the child reaches age 26 except as provided in Section 11, *Coverage for a Disabled Dependent Child*.

To be eligible for coverage under the Plan, a Dependent must reside within the United States.

***Note:*** Your Dependents may not enroll in the Plan unless you are also enrolled. In addition, if you and your Spouse are both covered under the Plan, 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 Plan, 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 12, *Other Important Information*.

## Cost of Coverage

You and The Maryland National Capital Park and Planning Commission share in the cost of the Plan. Your contribution amount depends on the Plan you select and the family members you choose to enroll.

Your contributions are deducted from your paychecks on a before-tax basis. 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.

***Note:*** The Internal Revenue Service generally does not consider Domestic Partners and their children eligible Dependents. Therefore, the value of The Maryland National Capital Park and Planning Commission's cost in covering a Domestic Partner may be imputed to the Participant as income. In addition, the share of the Participant's contribution that covers a Domestic Partner and their children may be paid using after-tax payroll deductions.

Your contributions are subject to review and The Maryland National Capital Park and Planning Commission reserves the right to change your contribution amount from time to time.

You can obtain current contribution rates by calling Human Resources‍‍‍**‍**.

## How to Enroll

To enroll, call Human Resources‍‍‍ within 31 days of the date you first become eligible for medical Plan coverage. If you do not enroll within 31 days, you will need to wait until the next annual Open Enrollment to make your benefit elections.

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 following January 1.

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 Human Resources‍‍ within 31 days of the event. Otherwise, you will need to wait until the next annual Open Enrollment to change your elections.

When Coverage Begins

Once Human Resources‍‍ receives your properly completed enrollment, coverage will begin on ‍the first day of the month following your date of hire‍‍.‍ Coverage for your Dependents will start on the date your coverage begins, provided you have enrolled them in a timely manner.

Coverage for a Spouse or Dependent stepchild that you acquire via marriage becomes effective the date of your marriage, provided you notify Human Resources‍‍ within 31 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, provided you notify Human Resources‍‍ within 31 days of the birth, adoption, or placement.

### If You Are Hospitalized When Your Coverage Begins

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

You should notify UnitedHealthcare of your hospitalization within 48 hours of the day your coverage begins, or as soon as is reasonably possible. For Benefit plans that have a Network Benefit level, Network Benefits are available only if you receive Covered Health Services from Network providers.

## 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, divorce, legal separation or annulment.
* Registering a Domestic Partner.
* The birth, legal 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.
* Your death or 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 *Children's Health Insurance Program (CHIP)* coverage as a result of loss of eligibility (you must contact Human Resources‍‍ within 60 days of termination).
* You or your Dependent become eligible for a premium assistance subsidy under *Medicaid* or *CHIP* (you must contact Human Resources‍‍ within 60 days of the date of determination of subsidy eligibility).
* You or your Dependent lose eligibility for coverage in the individual market, including coverage purchased through a public exchange or other public market established under the Affordable Care Act (Marketplace) (other than loss of eligibility for coverage due to failure to pay premiums on a timely basis or termination of coverage for cause, such as making a fraudulent claim or an intentional misrepresentation of a material fact) regardless of whether you or your Dependent may enroll in other individual market coverage, through or outside of a Marketplace.
* A strike or lockout involving you or your Spouse.
* A court or administrative order.

Unless otherwise noted above, if you wish to change your elections, you must contact Human Resources‍‍ within 31 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 Maryland National Capital Park and Planning Commission'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 Maryland National Capital Park and Planning Commission's medical plan outside of annual Open Enrollment.

# SECTION 3 - HOW THE PLAN WORKS

What this section includes:

* Accessing Benefits.
* Eligible Expenses.
* Coinsurance.

## Accessing 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.

Benefits are payable for Covered Health Services that are provided by or under the direction of a Physician or other provider regardless of their Network status. This Benefit plan does not provide a Network Benefit level or a Non-Network Benefit level.

UnitedHealthcare arranges for health care providers to participate in a Network. Depending on the geographic area, you may have access to Network providers. These providers have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from a Network provider, your Coinsurance level will remain the same. However, the portion that you owe may be less than if you received services from a non-Network provider because the Eligible Expense may be a lesser amount.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this section.

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

Air Ambulance transport provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this section.

Ground Ambulance transport provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this section.

You should show your identification card (ID card) every time you request health care services so that the provider knows that you are enrolled under the Plan.

Network Providers

UnitedHealthcare or its affiliates arrange for health care providers to participate in a Network. At your request, UnitedHealthcare will send you a directory of Network providers free of charge. Keep in mind, a provider's Network status may change. To verify a provider's status or request a provider directory, you can call UnitedHealthcare at the number on your ID card or log onto **www.myuhc.com**.

Network providers are independent practitioners and are not employees of The Maryland National Capital Park and Planning Commission or UnitedHealthcare. It is your responsibility to select your provider.

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

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

Looking for a 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 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.

Designated Providers

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

Eligible Expenses

The Maryland National Capital Park and Planning Commission has delegated to the initial discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.

Eligible Expenses are the amount the Claims Administrator determines that the Plan will pay for Benefits.

For Covered Health Services from non-Network providers, except as described below, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount the Plan will pay for Eligible Expenses.

* For Covered Health Services that are **Ancillary Services received at certain Network facilities on a non-Emergency basis from non-Network Physicians**, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.
* For Covered Health Services that are **non-Ancillary Services received at certain Network facilities on a non-Emergency basis from non-Network Physicians who have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a non-Ancillary Service is provided for which notice and consent has been satisfied as described below**, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.
* For Covered Health Services that are **Emergency Health Services provided by a non-Network provider**, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.
* For Covered Health Services that are **Air Ambulance services provided by a non-Network provider**, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the rates that would apply if the service was provided by a Network provider.

Eligible Expenses are determined in accordance with the Claims Administrator's reimbursement policy guidelines or as required by law, as described in the SPD.

Eligible Expenses are based on the following:

* When Covered Health Services are received from a Network provider that has agreed to participate in a Plan that does not officer a network of participating providers, Eligible Expenses are our contracted fee(s) with that provider.
* When Covered Health Services are received from a provider as a result of an Emergency or as arranged by us, including when there is no Network provider who is reasonably accessible or available to provide Covered Health Services, Eligible Expenses are an amount negotiated by us or an amount permitted by law.

**When Covered Health Services are received from a non-Network provider as described below, Eligible Expenses are determined as follows:**

* **For non-Emergency Covered Health Services received at certain Network facilities from non-Network Physicians** when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Health Service Act* with respect to a visit as defined by the Secretary (including non-Ancillary Services that have satisfied the notice and consent criteria but unforeseen urgent medical needs arise at the time the services are provided), the Eligible Expense is based on one of the following in the order listed below as applicable:
* The reimbursement rate as determined by a state *All Payer Model Agreement*.
* The reimbursement rate as determined by state law.
* The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the non-Network provider and the Claims Administrator.
* The amount determined by *Independent Dispute Resolution (IDR)*.

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

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

**For Emergency Health Services provided by a non-Network provider,** the Eligible Expense is based on either:

* + The reimbursement rate as determined by a state *All Payer Model Agreement*.
	+ The reimbursement rate as determined by state law.
* The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the non-Network provider and the Claims Administrator.
* The amount determined by *Independent Dispute Resolution (IDR)*.

**IMPORTANT NOTICE:** You are not responsible, and a non-Network provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.

* **For Air Ambulance transportation provided by a non-Network provider,**the Eligible Expense is based on either:
	+ The reimbursement rate as determined by a state *All Payer Model Agreement*.
* The reimbursement rate as determined by state law.
* The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the non-Network provider and the Claims Administrator.
* The amount determined by *Independent Dispute Resolution (IDR)*.

**IMPORTANT NOTICE:**You are not responsible, and a non-Network provider may not bill you, for amounts in excess of your Copayment, Coinsurance or deductible which is based on the rates that would apply if the service was provided by a Network provider.

* **For Emergency ground ambulance transportation provided by a non-Network provider,** the Eligible Expense, which includes mileage, is a rate agreed upon by the non-Network provider or, unless a different amount is required by applicable law, determined based upon the median amount negotiated with Network providers for the same or similar service.

**IMPORTANT NOTICE:** Non-Network providers may bill you for any difference between the provider’s billed charges and the Eligible Expense described here.

When Covered Health Services are received from a non-Network provider, except as described above, Eligible Expenses are determined as follows: (i) an amount negotiated by the Claims Administrator, (ii) a specific amount required by law (when required by law), or (iii) an amount the Claims Administrator has determined is typically accepted by a healthcare provider for the same or similar service. The Plan will not pay excessive charges. You are responsible for paying, directly to the non-Network provider, the applicable Coinsurance, Copayment or any deductible. Please contact the Claims Administrator if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any deductible to access the Advocacy Services as described below. Following the conclusion of the Advocacy Services described below, any responsibility to pay more than the Eligible Expense (which includes your Coinsurance, Copayment, and deductible) is yours. Don't Forget Your ID Card

Remember to show your 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.

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.

# SECTION 4 - PLAN HIGHLIGHTS

The table below provides an overview of ‍the Plan's ‍‍‍Maximums.

| Plan Features | Indemnity |
| --- | --- |
| Lifetime Maximum Benefit1There 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 |

1Generally 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); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Include covered health services and bracketed text in red as appropriate.

This table provides an overview of the Plan's coverage levels. For detailed descriptions of your Benefits, refer to Section 5, Additional Coverage Details.

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on *Eligible Expenses* or, for specific Covered Health Services as described in the definition of Recognized Amount in Section 13, *Glossary*.

| Covered Health Services‍  | Percentage of Eligible Expenses Payable by the Plan: |
| --- | --- |
| Acupuncture ServicesSee Section 6, *Additional Coverage Details*, for limits. | Plan pays 20% of the Medicare-approved amount and the Part B Medicare Deductible ‍ |
| Ambulance Services - Emergency OnlyEligible Expenses for ground and Air Ambulance transport provided by a non-Network provider will be determined as described in Section 3, *How the Plan Works*. | *Ground Ambulance*Plan pays 20% of the Medicare-approved amount and the Part B Medicare Deductible ‍Air AmbulancePlan pays 20% of the Medicare-approved amount and the Part B Medicare Deductible |
| Ambulance Services - Non-Emergency‍Ground or air ambulance, as the Claims Administrator determines appropriate. Eligible Expenses for ground and Air Ambulance transport provided by a non-Network provider will be determined as described in Section 3, *How the Plan Works*. | *Ground Ambulance*Plan pays 20% of the Medicare-approved amount and the Part B Medicare DeductibleAir Ambulance ‍Plan pays 20% of the Medicare-approved amount and the Part B Medicare Deductible |
| Ambulatory Surgical Center Services | Plan pays 20% of the Medicare-approved amount and the Part B Medicare Deductible ‍ |
| Anesthetics | Plan pays 20% of the Medicare-approved amount and the Part B Medicare Deductible ‍ |
| Cellular and Gene Therapy | 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. |
| Chemotherapy | Plan pays 20% of the Medicare-approved amount and the Part B Medicare Deductible ‍‍ |
| Clinical Trials | 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 |  |
| * Hospital Services - Inpatient Stay
 | Days 1- 60: Plan pays the Part A Medicare Deductible.Days 61-90: Plan pays the Part A Medicare approved participant amount per day.Over Days 91: Plan pays the Medicare-approved participant amount per day. |
| Durable Medical Equipment Provider Services (DME)See Section 5, *Additional Coverage Details*, for limits. | Plan pays 20% of the Medicare-approved amount and the Part B Medicare Deductible ‍ |
| Emergency CareEmergency services received at a non-Network Hospital are covered at the Network levelIf you are admitted as an inpatient to a Hospital directly from the Emergency room, you will not have to pay this Coinsurance. The Benefits for an Inpatient Stay in a Hospital will apply instead. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described under *Eligible Expenses* in Section 3: *How the Plan Works*.**Non-Emergent Health Services** | Plan pays 20% of the Medicare-approved amount and the Part B Medicare Deductible ‍‍Plan pays 20% of the Medicare-approved amount and the Part B Medicare Deductible ‍‍ |
| Enteral Nutrition | Plan pays 20% of the Medicare-approved amount and the Part B Medicare Deductible . |
| Habilitative Services | Depending upon where the Covered Health Service is provided, Benefits for habilitative services will be the same as those stated under *Rehabilitation Therapy* ‍*‍*stated in this section. |
| Hearing AidsSee Section 5, *Additional Coverage Details*, for limits | Plan pays 80% of Eligible Expenses after you meet the Annual Deductible |
| Hospice Care Provider ServicesSee Section 5, *Additional Coverage Details*, for limits. | Plan pays 20% of the Medicare-approved amount and the Part B Medicare Deductible ‍‍.Plan pays 5% of the Medicare-approved amount for inpatient respite care‍ |
| Hospital Pre-Admission Tests | Plan pays 20% of the Medicare-approved amount and the Part B Medicare Deductible .‍ |
| Hospital Services(Copay is per admission) | Days 1- 60: Plan pays the Part A Medicare Deductible.Days 61-90: Plan pays the Part A Medicare approved participant amount per day.Over Days 91: Plan pays the Medicare-approved participant amount per day. |
| Laboratory Tests and X-rays | Plan pays 20% of the Medicare-approved amount and the Part B Medicare Deductible  |
| Medical Supplies | Plan pays 20% of the Medicare-approved amount and the Part B Medicare Deductible  |
| Medical Transportation ServicesEligible Expenses for Air Ambulance transport provided by a non-Network provider will be determined as described in Section 3, *How the Plan Works*.  | Plan pays 20% of the Medicare-approved amount and the Part B Medicare Deductible  |
| Mental Health Services |  |
| * Hospital Services(Copay is per admission)
 | Days 1- 60: Plan pays the Part A Medicare Deductible.Days 61-90: Plan pays the Part A Medicare approved participant amount per day.Over Days 91: Plan pays the Medicare-approved participant amount per day. |
| * Office Visit‍
 | Plan pays 20% of the Medicare-approved amount and the Part B Medicare Deductible .‍‍‍‍ |
| See Section 6, *Additional Coverage Details*, for limits. |  |
| Nurse-Practitioner Services | Plan pays 20% of the Medicare-approved amount and the Part B Medicare Deductible .‍‍‍‍ |
| Oral Surgery and Dental Services | Plan pays 20% of the Medicare-approved amount and the Part B Medicare Deductible .‍‍‍‍ |
| Organ/Tissue Transplants‍ | Plan pays 20% of the Medicare-approved amount and the Part B Medicare Deductible .‍‍‍‍ |
| Outpatient Occupational Therapy‍See Section 5, *Additional Coverage Details*, for limits. | Plan pays 20% of the Medicare-approved amount and the Part B Medicare Deductible .‍‍‍‍‍‍‍Outpatient Rehabilitative Services received in connection with the Habilitative Services are not subject to any visit limit, benefits are covered in full 100% no copay: Habilitative Services:Benefits for Habilitative Services for children under the age of 19 (but not including Habilitative Services provided through early intervention and school services). |
| Physician Services‍Covered Health Care Services provided by an non -Network Physician in certain Network facilities will apply the same cost sharing (Copayment, Coinsurance and applicable deductible) as if those services were provided by a Network provider; however Eligible Expenses, will be determined as described below under Eligible Expenses in this Schedule of Benefits. |  |
| * ‍Office Visit
 | Plan pays 20% of the Medicare-approved amount and the Part B Medicare Deductible . ‍‍‍ |
| Preventive Health Care Benefits |  |
| * Office Visit
 | 100% |
| * Breast Pumps
 | 100% |
| * All other services (except Office Visit)
 | 100% |
| Psychologist Services | Plan pays 20% of the Medicare-approved amount and the Part B Medicare Deductible . |
| Radiation Therapy | Plan pays 20% of the Medicare-approved amount and the Part B Medicare Deductible . |
| Rehabilitation Therapy |  |
| * Inpatient
 | Plan pays 20% of the Medicare-approved amount and the Part B Medicare Deductible . |
| * Outpatient‍
 | Plan pays 20% of the Medicare-approved amount and the Part B Medicare Deductible .‍‍‍‍‍‍‍Outpatient Rehabilitative Services received in connection with the Habilitative Services are not subject to any visit limit, benefits are covered in full 100% no copay: Habilitative Services:Benefits for Habilitative Services for children under the age of 19 (but not including Habilitative Services provided through early intervention and school services). |
| Second Surgical Opinion | Plan pays 20% of the Medicare-approved amount and the Part B Medicare Deductible .‍ |
| Skilled Nursing Facility Confinement Services | Days 1-20: Covered by Medicare 100%Over Days 21: Plan pays Medicare-approved participant amount per day |
| Speech Therapy‍ | Plan pays 20% of the Medicare-approved amount and the Part B Medicare Deductible .Outpatient Rehabilitative Services received in connection with the Habilitative Services are not subject toany visit limit , benefits are covered in full 100% no copay: Habilitative Services:Benefits for Habilitative Services for children under the age of 19 (but not including Habilitative Services provided through early intervention and school services).  |
| Spinal Treatment‍See Section 6, *Additional Coverage Details*, for limits. | Plan pays 20% of the Medicare-approved amount and the Part B Medicare Deductible . |
| Substance Use Disorder Services |  |
| * Hospital Services
 | Days 1- 60: Plan pays the Part A Medicare Deductible.Days 61-90: Plan pays the Part A Medicare approved participant amount per day.Over Days 91: Plan pays the Medicare-approved participant amount per day. |
| * Office Visits‍
 | Plan pays 20% of the Medicare-approved amount and the Part B Medicare Deductible .‍‍‍‍ |
|  |  |
| Travel and Lodging(If services rendered by a Designated Facility) | For patient and companion(s) of patient undergoing cancer, ‍‍‍Congenital Heart Disease treatment or transplant procedures |
| Urgent Care Center Services‍ | Plan pays 20% of the Medicare-approved amount and the Part B Medicare Deductible  |
| Virtual Care Services Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.Virtual Care Services are not Telehealth. See Physician's Office Services, Telehealth. | Plan pays 20% of the Medicare-approved amount and the Part B Medicare Deductible .‍‍‍‍ |

2These 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 Services*, *Hospital Services* and *Laboratory Tests and X-rays.*

# SECTION 5 - ADDITIONAL COVERAGE DETAILS

What this section includes:

* Covered Health Services for which the Plan pays Benefits.

This section supplements the second table in Section 4, Plan Highlights.

While the table provides you with Benefit limitations along with ‍‍Coinsurance‍ information for each Covered Health Service, this section includes descriptions of the Benefits. These descriptions include any additional limitations that may apply‍‍‍‍‍. 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 7, Exclusions and Limitations.

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

## Acupuncture Services

Acupuncture services for pain therapy when the service is performed by a provider in the provider's office when traditional pain management treatment has failed or for the following conditions:

* Nausea and vomiting associated with pregnancy.
* Nausea and vomiting associated with chemotherapy.
* Postoperative nausea and vomiting.
* The treatment of pain associated with ANY of the following conditions:
* Migraine or tension headache.
* Osteoarthritic knee pain.
* Low back pain.
* Neck pain.

Ambulance Services - Emergency only

Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency health services can be performed. See Section 14, Glossary for the definition of Emergency.

## Ambulance Services - Non-Emergency

Transportation by professional ambulance (not including air ambulance) between medical facilities.

Transportation by regularly-scheduled airline, railroad or air ambulance, to the nearest medical facility qualified to give the required treatment.

Prior Authorization Requirement

In most cases, the Claims Administrator will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency Air ambulance services (including any affiliated non-Emergency ground ambulance transport in conjunction with non-Emergency air ambulance transport), please remember that you must obtain prior authorization as soon as possible prior to transport.

## Ambulatory Surgical Center Services

A Center's services given within 72 hours before or after a surgical procedure. The services must be given in connection with the procedure.

## Anesthetics

The Plan covers general anesthetics and local anesthetics.

## 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 a Personal Health Support Nurse‍‍‍;
* call CRS toll-free at (866) 936-6002; or
* visit www.myoptumhealthcomplexmedical.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 each Covered Health Service described in Section 4, *Plan Highlights*.

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

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 Network).

## Cellular and Gene Therapy

Cellular Therapy and Gene Therapy received on an inpatient or outpatient basis at a Hospital or on an outpatient basis at an Alternate Facility or in a Physician's office.

Benefits for CAR-T therapy for malignancies are provided as described under *Transplantation Services*.

## Chemotherapy

The Plan covers chemotherapy treatment.

## 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 Personal Health Support as soon as the possibility of participation in a Clinical Trial arises. If‍‍ Personal Health Support is not notified, you will be responsible for paying all charges and no Benefits will be paid.

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 include the facility charge and the charge for supplies and equipment. 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 the Claims Administrator ‍‍‍or Personal Health Support to be proven procedures for the involved diagnoses. Contact the Claims Administrator at 1-888-936-7246 ‍‍‍‍or Personal Health Support 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 each Covered Health Service described in Section 4, *Plan Highlights*.

Please remember that you should notify the Claims Administrator or Personal Health Support‍‍ Personal Health Support‍ as soon as CHD is suspected or diagnosed.‍‍‍‍‍‍‍‍‍‍‍‍‍‍‍‍

***Note***: The services described under *Travel and Lodging* are Covered Health Services only in connection with CHD services received at a Congenital Heart Disease Resource Services program.

## Durable Medical Equipment Provider Services (DME)

Durable Medical Equipment means equipment which meets all of the following:

* It is for repeated use and is not a consumable or disposable item.
* It is used primarily for a medical purpose.
* It is appropriate for use in the home.

Some examples of Durable Medical Equipment are:

* Appliances which replace a lost body organ or part or help an impaired one to work.
* Hospital-type beds.
* Equipment needed to increase mobility, such as a wheelchair.
* Respirators or other equipment for the use of oxygen.
* Monitoring devices.
* 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.

UnitedHealthcare provides Benefits only for a single purchase (including repair/ replacement) of a type of DME once every three calendar years.

UnitedHealthcare decides whether to cover the purchase or rental of the equipment.

## Emergency Care

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. When Emergency Care is required and results in a confinement, the Covered Person (or that person's representative or Physician) must call Personal Health Support‍‍ within one working day of the date the confinement begins.

A working day is a business day of UnitedHealthcare. It does not include Saturday, Sunday or a State or Federal holiday. If it is not reasonably possible to call Personal Health Support‍‍ within one working day, Care Coordination must be notified as soon as reasonably possible.

When the Emergency Care has ended, however, Personal Health Support‍‍ must be called before any additional services that require notification are received.

 Benefits under this section are available for services to treat a condition that does not meet the definition of an Emergency.

## Enteral Nutrition

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

Hearing Aids

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

Benefits are available for a hearing aid that is purchased through a licensed audiologist, hearing aid dispenser, otolaryngologist or other authorized provider. Benefits are provided for the hearing aid and associated fitting charges and testing.

Benefits are also provided for certain over-the-counter hearing aids for Covered Persons age 18 and older who have mild to moderate hearing loss.

Benefits for over-the-counter hearing aids do not require any of the following:

* A medical exam.
* A fitting by an audiologist.
* A written prescription.

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

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

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

Benefits are limited to up to $3,000 per member every 36 months

## Hospice Care Provider Services

* Room and Board.
* Other Services and Supplies.
* Part-time nursing care by or supervised by a registered graduate nurse (R.N.).
* Counseling for the patient and Covered Family Members.
* Bereavement counseling for Covered Family Members. Services must be given within six months after the patient's death. Covered Health Services are limited to a total of 15 visits for each family.

Counseling must be given by a Licensed Counselor.

Services for the patient must be given in an inpatient Hospice facility or in the patient's home.

The Physician must certify that the patient is terminally ill with six months or less to live.

Any counseling services given in connection with a terminal illness will not be considered as Mental Disorder Treatment.

## Hospital Pre-Admission Tests

Tests performed on a Covered Person in a Hospital before confinement as a resident inpatient provided they meet all of the following requirements:

* The tests are related to the performance of scheduled surgery.
* The tests have been ordered by a Physician after a condition requiring surgery has been diagnosed and Hospital admission for surgery has been requested by the Physician and confirmed by the Hospital.
* The Covered Person is subsequently admitted to the Hospital, or the confinement is canceled or postponed because a Hospital bed is unavailable or because there is a change in the Covered Person's condition which precludes the surgery.

Hospital Services

* Room and Board.

Covered Health Services for a private room are limited to the regular daily charge made by the Hospital for a semi-private room.

* Other Services and Supplies.
* Emergency Room.

Emergency room services are covered only if it is determined that the services are Covered Health Services and there is not a less intensive or more appropriate place of service, diagnostic or treatment alternative that could have been used in lieu of emergency room services. If the UnitedHealthcare, at its discretion, determines that a less intensive or more appropriate treatment could have been given then no benefits are payable.

Laboratory Tests and X-rays

X-rays or tests for diagnosis or treatment.

Benefits are limited to 18 Presumptive Drug Tests per calendar year. Benefits are limited to 18 Definitive Drug Tests per calendar year.

## Medical Supplies

* Surgical supplies (such as bandages and dressings). Supplies given during surgery or a diagnostic procedure are included in the overall cost for that surgery or diagnostic procedure.
* Blood or blood derivatives only if not donated or replaced.

Medical Transportation Services

Transportation by professional ambulance, other than Air Ambulance, to and from a medical facility.

Transportation by regularly-scheduled airline, railroad or Air Ambulance, to the nearest medical facility qualified to give the required treatment.

## Mental Health Services

Mental Health Services include those received on an inpatient or outpatient basis in a Hospital and an Alternate Facility or in a provider's office. All services must be provided by or under the direction of a behavioral health provider who is properly licensed and qualified by law and acting within the scope of their licensure.

Benefits include the following levels of care:

* Inpatient treatment.
* Partial Hospitalization/Day Treatment.
* Intensive Outpatient Treatment.
* Outpatient treatment.

Inpatient treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

* Diagnostic evaluations, assessment and treatment and/or procedures.
* Medication management.
* Individual, family, and group therapy.
* Crisis intervention.

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

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for assistance in locating a provider and coordination of care.

## Nurse-Practitioner Services

Services of a licensed or certified Nurse-Practitioner acting within the scope of that license or certification.

## Oral Surgery and Dental Services

* Oral surgery if needed as a necessary, but incidental, part of a larger service in treatment of an underlying medical condition.
* The following services and supplies are covered only if needed because of accidental injury to natural teeth:
* Oral surgery.
* Full or partial dentures.
* Fixed bridge work.
* Prompt repair to natural teeth.
* Crowns.

Organ/Tissue Transplants

Services and supplies for necessary organ or tissue transplants are payable under this Plan. Certain transplants (called Qualified Procedures) are only payable if they are performed at a Designated Facility. See Transplant Benefit Management Program for information on how Qualified Procedures are paid.

Personal Health Support‍‍ must be notified at least seven working days before the scheduled date of any of the following or as soon as reasonably possible:

* The evaluation.
* The donor search.
* The organ procurement/tissue harvest.
* The transplant procedure.

Services and supplies for necessary organ or tissue transplants are payable under this Plan.

**Donor Charges for Organ/Tissue Transplants**

* In the case of an organ or tissue transplant, donor charges are considered Covered Health Services ONLY if the recipient is a Covered Person under this Plan. If the recipient is not a Covered Person, no benefits are payable for donor charges.
* The search for bone marrow/stem cell from a donor who is not biologically related to the patient is not considered a Covered Health Service UNLESS the search is made in connection with a transplant procedure arranged by a Designated Facility.

If a Qualified Procedure, listed below, is a Covered Health Service and performed at a Designated Facility, the Medical Care and Treatment and Travel and Lodging provisions described below apply.

**Qualified Procedures**

* Heart Transplants.
* Lung transplants.
* Heart/Lung transplants.
* Liver transplants.
* Kidney transplants.
* Pancreas transplants.
* Kidney/Pancreas transplants.
* Bone Marrow/Stem Cell transplants.
* Other transplant procedures when UnitedHealthcare determines that it is necessary to perform the procedure at a Designated Facility.

**Medical Care and Treatment**

The Covered Health Services for services provided in connection with the transplant procedure include:

* Pre-transplant evaluation for one of the procedures listed above.
* Organ acquisition and procurement.
* Hospital and physician fees.
* Transplant procedures.
* Follow-up care for a period up to one year after the transplant.
* Search for bone marrow/stem cell from a donor who is not biologically related to the patient. If a separate charge is made for bone marrow/stem cell search, a Maximum Benefit of $25,000 is payable for all charges made in connection with the search.

## Outpatient Occupational Therapy

Services of a licensed occupational therapist, provided the following conditions are met:

* The therapy must be ordered and monitored by a Physician.
* The therapy must be given in accordance with a written treatment plan approved by a Physician. The therapist must submit progress reports at the intervals stated in the treatment plan.
* The therapy must be expected to result in significant, objective, measurable physical improvement in the Covered Person's condition within 2 months of the start of the treatment.

Outpatient Rehabilitative Services received in connection with the Habilitative Services are not subject to any visit limit , benefits are covered in full 100% no copay: Habilitative Services:

Benefits for Habilitative Services for children under the age of 19 (but not including Habilitative Services provided through early intervention and school services).

## Outpatient Physical Therapy

Services of a licensed physical therapist, provided the following conditions are met:

* The therapy must be ordered and monitored by a Physician.
* The therapy must be given in accordance with a written treatment plan approved by a Physician. The therapist must submit progress reports at the intervals stated in the treatment plan.
* The therapy must be expected to result in significant, objective, measurable physical improvement in the Covered Person's condition within 2 months of the start of the treatment.

Outpatient Rehabilitative Services received in connection with the Habilitative Services are not subject to any visit limit , benefits are covered in full 100% no copay: Habilitative Services:

Benefits for Habilitative Services for children under the age of 19 (but not including Habilitative Services provided through early intervention and school services).

## Physician Services

**Medical Care and Treatment**

* Hospital, office and home visits.
* Emergency room services.

**Surgery**

Services for surgical procedures.

**Reconstructive Surgery**

* Reconstructive surgery to improve the function of a body part when the malfunction is the direct result of one of the following:
* Birth defect.
* Sickness.
* Surgery to treat a Sickness or accidental injury.
* Accidental injury.
* Reconstructive breast surgery following a necessary 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.
* Reconstructive surgery to remove scar tissue on the neck, face, or head if the scar tissue is due to Sickness or accidental injury.
* Cosmetic procedures are excluded from coverage. Procedures that correct a congenital anomaly without improving or restoring physiologic function are considered cosmetic procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an injury, sickness or congenital anomaly does not classify surgery or other procedures done to relieve such consequences or behavior as a reconstructive procedure.

Notify UnitedHealthcare for Non-Network benefits 5 business days before receiving services. By notifying UnitedHealthcare, UnitedHealthcare can verify that the service is a reconstructive procedure rather than cosmetic one.

**Assistant Surgeon Services**

Eligible Expenses for assistant surgeon services are limited to 1/5 of the amount of Eligible Expenses for the surgeon's charge for the surgery. An assistant surgeon must be a Physician. Surgical assistant's services are not covered.

**Multiple Surgical Procedures**

Multiple surgical procedures means more than one surgical procedure performed during the same operative session. Eligible Expenses for multiple surgical procedures are limited as follows:

* Eligible Expenses for a secondary procedure are limited to 50% of the Eligible Expenses that would otherwise be considered for the secondary procedure had it been performed during a separate operative session.
* Eligible Expenses for any subsequent procedure are limited to 25% of the Eligible Expenses that would otherwise be considered for the subsequent procedure had it been performed during a separate operative session.

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.

The Plan pays for services for preventive medical care provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital.

In general, the Plan pays preventive care Benefits based on the recommendations of the U.S. Preventive Services Task Force (USPSTF) although other preventive care services may be covered as well. Your Physician may recommend additional services based on your family or medical history. Examples of preventive medical care are listed below and provide a guide of what is considered a Covered Health Service.

For questions about your preventive care Benefits under this Plan call the number on your ID card.

**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. These Benefits are described under Section 5, *Plan Highlights* under *Covered Health Services*.

Benefits are only available if breast pumps are obtained from a DME provider or Physician.

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

* Which pump is the most cost effective;
* Whether the pump should be purchased or rented;
* Duration of a rental;
* Timing of an acquisition.

## Psychologist Services

Covered Health Services provided by a person who specializes in clinical psychology and fulfills one of these requirements:

* A person licensed or certified as a psychologist.
* A Member or Fellow of the American Psychological Association, if there is no government licensure or certification required.

Radiation Therapy

The Plan covers radiation therapy.

## Rehabilitation Therapy Inpatient

* Services of a Hospital or Rehabilitation Facility for room, board, care and treatment during a confinement.
* Inpatient rehabilitative therapy is a Covered Health Service only if intensive and multidisciplinary rehabilitation care is necessary to improve the patient's ability to function independently.

**Outpatient**

* Services of a Hospital or Alternate Facility.
* Covered Health Services are limited to 20 days of therapy each Calendar Year. A day of therapy includes all services given by or visits to the Hospital or CORF in any one day.
* Covered Health Services for each day of therapy reduces the number of visits under Covered Health Services for Outpatient Physical Therapy, Outpatient Occupational Therapy or Speech Therapy. This reduction only applies to days of therapy during which the therapy includes services given by a physical therapist, occupational therapist or speech therapist.
* Covered Health Services include pulmonary rehabilitation, cardiac rehabilitation.

For outpatient rehabilitation services for speech therapy, the Plan will pay Benefits for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, or Congenital Anomaly.

Second Surgical Opinion

The Plan covers Second Surgical physician services.

## Skilled Nursing Facility Services

* Room and Board.

Covered Health Services for Room and Board are limited to the facility's regular daily charge for a semi-private room.

## Speech Therapy

Services of a licensed speech therapist.

These services must be given to restore speech lost or impaired due to one of the following:

* Surgery, radiation therapy or other treatment which affects the vocal cords.
* Cerebral thrombosis (cerebral vascular accident).
* Brain damage due to accidental injury or organic brain lesion (aphasia).
* Accidental injury.

The therapy must be expected to result in significant, objective, measurable physical improvement in the Covered Person's condition within 2 months of the start of the treatment.

Outpatient Rehabilitative Services received in connection with the Habilitative Services are not subject to any visit limit , benefits are covered in full 100% no copay: Habilitative Services:

Benefits for Habilitative Services for children under the age of 19 (but not including Habilitative Services provided through early intervention and school services).

**Speech Therapy for Children Under Age 3**

Services of a licensed speech therapist for treatment given to a child under age 3 whose speech is impaired due to one of the following conditions:

* Infantile autism.
* Developmental delay or cerebral palsy.
* Hearing impairment.
* Major congenital anomalies that affect speech such as, but not limited to, cleft lip and cleft palate.

Covered Health Services are limited to 20 visits each calendar year.

Spinal Treatment

Benefits for Spinal Treatment when provided by a Spinal Treatment provider in the provider's office.

Benefits include diagnosis and related services and are limited to one visit and treatment per day.

 Benefits for Spinal Treatments are unlimited per calendar year.

Benefits prior to reimbursement of the 10th visit, supporting documentation must be submitted (including, but not limited to, an evaluation and treatment plan).

## Substance-Related and Addictive Disorders Services

Substance-Related and Addictive Disorders Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility, or in a provider's office. All services must be provided by or under the direction of a behavioral health provider who is properly licensed and qualified by law and acting within the scope of their licensure.

Benefits include the following levels of care:

* Inpatient treatment.
* Partial Hospitalization/Day Treatment.
* Intensive Outpatient Treatment.
* Outpatient treatment.

Inpatient treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

* Diagnostic evaluations, assessment and treatment and/or procedures
* Medication management.
* Individual, family, and group therapy.
* Crisis intervention.

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

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for assistance in locating a provider and coordination of care.

## Urgent Care Center Services

The Plan pays for Covered Health Services received at an Urgent Care Center, as defined in Section 14, *Glossary*. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under Physician's Office Services - *Sickness and Injury*.

## Virtual Care Services

Virtual care for Covered Health Services that include the diagnosis and treatment of low acuity medical conditions for Covered Persons, through live audio with video technology or audio only. Virtual visits provide communication of medical information in real-time between the patient and a distant Physician or health care specialist, through use of interactive audio with video communications or audio only equipment outside of a medical facility (for example, from home or from work).

Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.

Benefits are available for the following:

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

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

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

Benefits under this section do not include email, fax and standard telephone calls, or for telehealth/telemedicine visits that occur within medical facilities (*CMS* defined originating facilities).

# SECTION 6 - CLINICAL PROGRAMS AND RESOURCES

What this section includes:

Health and well-being resources available to you, including:

* Consumer Solutions and Self-Service Tools.
* Disease and Condition Management Services.

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

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

*NOTE:*

Information obtained through the services identified in this section is based on current medical literature and on Physician review. It is not intended to replace the advice of a doctor. The information is intended to help you make more informed health care decisions and take a greater responsibility for your own health. UnitedHealthcare and The Maryland National Capital Park and Planning Commission 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, your choosing of which provider to seek professional medical care from or your choosing or not choosing specific treatment.

Consumer Solutions and Self-Service Tools

### Health Survey

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

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

If you need any assistance with the online survey, please call the number on your ID card.

### Reminder Programs

To help you stay healthy, UnitedHealthcare may send you and your covered Dependents reminders to schedule recommended screening exams. Examples of reminders include:

* Mammograms for women.
* Pediatric and adolescent immunizations.
* Cervical cancer screenings for women.
* Comprehensive screenings for individuals with diabetes.
* Influenza/pneumonia immunizations for enrollees.

There is no need to enroll in this program. You will receive a reminder automatically if you have not had a recommended screening exam.

### Decision Support

In order to help you make informed decisions about your health care, UnitedHealthcare has a program called Decision Support. This program targets specific conditions as well as the treatments and procedures for those conditions.

This program offers:

* Access health care information.
* Support by a nurse to help you make more informed decisions in your treatment and care.
* Expectations of treatment.
* Information on providers and programs.

Conditions for which this program is available include:

* Back pain.
* Knee & hip replacement.
* Prostate disease.
* Prostate cancer.
* Benign uterine conditions.
* Breast cancer.
* Coronary disease.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on your ID card.

### 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 self-service tools.

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.
* Complete a health survey to help you identify health habits you may improve, learn about healthy lifestyle techniques and access health improvement resources.
* Use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area.
* Use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

Registering on www.myuhc.com

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

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

* Make real-time inquiries into the status and history of your claims.
* View eligibility and Plan Benefit information‍‍‍‍.
* View and print all of your Explanation of Benefits (EOBs) online.
* Order a new or replacement ID card or print a temporary ID card.

**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.

Disease Management Services

If you have been diagnosed with certain chronic medical conditions you may be eligible to participate in a disease management program at no additional cost to you. The heart failure, coronary artery disease, diabetes, asthma and Chronic Obstructive Pulmonary Disease (COPD) programs are designed to support you. This means that you will receive free educational information, and may even be called by a registered nurse who is a specialist in your specific medical condition. This nurse will be a resource to advise and help you manage your condition.

These programs offer:

* Educational materials that provide guidance on managing your specific chronic medical condition. This may include information on symptoms, warning signs, self-management techniques, recommended exams and medications.
* Access to educational and self-management resources on a consumer website.
* An opportunity for the disease management nurse to work with your Physician to ensure that you are receiving the appropriate care.
* Access to and one-on-one support from a registered nurse who specializes in your condition. Examples of support topics include:
* Education about the specific disease and condition.
* Medication management and compliance.
* Reinforcement of on-line behavior modification program goals.
* Preparation and support for upcoming Physician visits.
* Review of psychosocial services and community resources.
* Caregiver status and in-home safety.
* Use of mail-order pharmacy and Network providers.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on your ID card.

## Complex Medical Conditions Programs and Services

### Cancer Resource Services (CRS) Program

Your Plan offers Cancer Resource Services (CRS) program to provide you with access to information and member assistance through a team of specialized cancer nurse consultants and access to one of the nation’s leading cancer programs.

To learn more about *CRS*, visit www.myoptumhealthcomplexmedical.com or call the number on your ID card or call the program directly at 1-866-936-6002.

Coverage for oncology services and oncology-related services are based on your health plan’s terms, exclusions, limitations and conditions, including the plan’s eligibility requirements and coverage guidelines. Participation in this program is voluntary.

Your Plan Sponsor is providing you with Travel and Lodging assistance. Refer to the *Complex Medical Conditions* *Travel and Lodging Assistance Program*.

### Kidney Resource Services (KRS) programEnd-Stage Renal Disease (ESRD)

The Kidney Resource Services program provides Covered Persons with access to a registered nurse advocate who specializes in helping individuals live with kidney disease. As a participant in the KRS program, you’ll work with a nurse who will provide you with support and information. The nurse can help you manage other conditions, such as diabetes and high blood pressure. He or she can also help you find doctors, specialists and dialysis centers. This program is available at no extra cost to you.

With KRS, you have access to a registered nurse who specializes in kidney health. This program is designed to help you be your own best advocate for your health. You may have been referred to the KRS program by your medical provider or from past claim information. As part of your health insurance benefits, it’s available at no extra cost to you.

KRS nurse advocates are available, Monday through Friday toll-free at 1-866-561-7518 (TTY: 711).

Coverage for dialysis and kidney-related services are based on your health plan’s terms, exclusions, limitations and conditions, including the plan’s eligibility requirements and coverage guidelines. Participation in this program is voluntary.

### Congenital Heart Disease (CHD) Resource Services

UnitedHealthcare provides a program that identifies and supports a Covered Person who has Congenital Heart Disease (CHD) through all stages of treatment and recovery. This program will work with you and your Physicians, as appropriate, to offer support and education on CHD. Program features include clinical management by specialized CHD Nurses, support from specialized Social Workers, assistance with choosing Physicians and Facilities, and access to Designated Providers.

To learn more about CHD Resource Services program, visit www.myoptumhealthcomplexmedical.com or call UnitedHealthcare at the number on your ID card.

Coverage for CHD surgeries and related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary. If you are considering any CHD surgeries you must contact CHD Resource Services prior to surgery to enroll in the program in order for the surgery to be a considered a Covered Health Service under the Plan.

Your Plan Sponsor is providing you with Travel and Lodging assistance. Refer to the Complex Medical Conditions Travel and Lodging Assistance Program.

### Transplant Resource Services (TRS) Program

Your Plan offers Transplant Resource Services (TRS) program to provide you with access to one of the nation's leading transplant programs. Receiving transplant services through this program means your transplant treatment is based on a "best practices" approach from health care professionals with extensive expertise in transplantation.

To learn more about Transplant Resource Services, visit **www.myoptumhealthcomplexmedical.com** or call the number on your ID card.

Coverage for transplant and transplant-related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary.

***Complex Medical Conditions Travel and Lodging Assistance Program for the Covered Health Services described below.***

Your Plan Sponsor may provide you with Travel and Lodging assistance for certain Covered Health Services. Travel and Lodging assistance is only available for you or your eligible family member if you meet the qualifications for the benefit, including receiving care at a Designated Provider and the requisite distance from your home address to the facility is at least 50 miles. Eligible Expenses are reimbursed after the expense forms have been completed and submitted with the appropriate receipts.

If you have specific questions regarding the Complex Medical Conditions Travel and Lodging Assistance Program, please call the number on your ID card.

***Travel and Lodging Expenses***

The Plan covers expenses for travel and lodging for the Covered Person and a travel companion, provided the Covered Person is not covered by Medicare as follows:

* Transportation of the Covered Person and one companion who is traveling on the same day(s) to and/or from the site of the qualified procedure provided by a Designated Provider for care related to one of the programs listed below.
* The Eligible Expenses for lodging for the Covered Person (while not a Hospital inpatient) and one companion.
* If the Covered Person is an enrolled Dependent minor child, the transportation expenses of two companions will be covered.
* Travel and lodging expenses are only available if the Covered Person resides at least 50 miles from the Designated Provider.
* Reimbursement for certain lodging expenses for the Covered Person and his/her companion(s) may be included in the unearned taxable income of the Plan participant if the reimbursement exceeds the per diem rate.
* The cancer and congenital heart disease programs offer a combined overall lifetime maximum of $10,000 per Covered Person for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures.

The Claims Administrator must receive valid receipts for such charges before you will be reimbursed. Reimbursement is as follows:

***Lodging Reimbursement Assistance***

* A per diem rate, up to $50.00 per day, for the Covered Person or the caregiver if the Covered Person is in the Hospital.
* A per diem, up to $100.00 per day, for the Covered Person and one caregiver. When a child is the Covered Person, two persons may accompany the child.

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.

Women's Health/Reproductive

### Maternity Support Program

If you are pregnant or thinking about becoming pregnant, and you are enrolled in the medical Plan, you can get valuable educational information, advice and comprehensive case management by calling the number on your ID card. Your enrollment in the program will be handled by an OB nurse who is assigned to you.

This program offers:

* Enrollment by an OB nurse.
* Pre-conception health coaching.
* Written and online educational resources covering a wide range of topics.
* First and second trimester risk screenings.
* Identification and management of at- or high-risk conditions that may impact pregnancy.
* Pre-delivery consultation.
* Coordination with and referrals to other benefits and programs available under the medical plan.
* A phone call from a nurse approximately two weeks postpartum to provide information on postpartum and newborn care, feeding, nutrition, immunizations and more.
* Post-partum depression screening.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first trimester of Pregnancy. You can enroll any time, up to your 34th week. To enroll, call the number on your ID card.

As a program participant, you can always call your nurse with any questions or concerns you might have.

**Note:** you may have access to certain mobile apps for personalized support to help live healthier. Please call the number on your ID card for additional information.

# SECTION 7 - EXCLUSIONS AND LIMITATIONS: 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 5, *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 5, *Additional Coverage Details*, those limits are stated in the corresponding Covered Health Service category in Section 4, *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 4, *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 SPD 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 SPD specifically states that the list "is limited to."**

## Alternative Treatments

. acupressure;

2. aromatherapy;

3. hypnotism;

4. massage therapy;

. rolfing (holistic tissue massage); and

. art therapy, music therapy, dance therapy, animal-assisted therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Integrative Health (NCCIH)* of the *National Institutes of Health*. This exclusion does not apply to non-manipulative osteopathic care for which Benefits are provided as described in Section 5, *Additional Coverage Details.*

7.wilderness, adventure, camping, outdoor, or other similar programs*.*

## Dental

. dental care, except as identified under *Oral Surgery and Dental Services* in Section 5, *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 caries resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded.

. 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 preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement or the *Health Resources and Services Administration (HRSA)* requirement. This exclusion also does not apply to accident-related dental services for which Benefits are provided as described under *Oral Surgery and Dental Services* in Section 5, *Additional Coverage Details*.

. 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 *Oral Surgery and Dental Services* in Section 5, *Additional Coverage Details*.

. dental braces (orthodontics);

. dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia; 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 5, *Additional Coverage Details*.

. 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

. devices used specifically as safety items or to affect performance in sports-related activities;

. orthotic appliances and devices that straighten or re-shape a body part, except as described under *Durable Medical Equipment Provider Services (DME)* in Section 5, *Additional Coverage Details*: this exclusion does not apply to cranial molding helmets and cranial banding that meet clinical criteria.

Examples of excluded orthotic appliances and devices include but are not limited to, foot orthotics or any orthotic braces available over-the-counter.

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

* blood pressure cuff/monitor;
* enuresis alarm;
* non-wearable external defibrillator;
* trusses;
* ultrasonic nebulizers;

. the repair and replacement of prosthetic devices when damaged due to misuse, malicious breakage or gross neglect;

. the replacement of lost or stolen prosthetic devices;

. devices and computers to assist in communication and speech except for dedicated speech generating devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment* *Provider Services (DME)* in Section 5, *Additional Coverage Details*; and

. oral appliances for snoring.

. Powered and non-powered exoskeleton devices.

## Drugs

. prescription drugs for outpatient use that are filled by a prescription order or refill;

. 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;

. growth hormone therapy;

. non-injectable medications given in a Physician's office except as required in an Emergency and consumed in the Physician's office; and

. over the counter drugs and treatments.

. Compounded drugs that contain certain bulk chemicals. Compounded drugs that are available as a similar commercially available Pharmaceutical Product.

## 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 13, *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. Examples include the cutting or removal of corns and calluses.
2. Nail trimming, nail cutting, or nail debridement.
3. Hygienic and preventive maintenance foot care. Examples include:
* Cleaning and soaking the feet.
* Applying skin creams in order to maintain skin tone.

This exclusion does not apply to preventive foot care due to conditions associated with metabolic, neurologic or peripheral vascular disease.

4. Treatment of flat feet.

5. Treatment of subluxation of the foot.

## Medical Supplies and Equipment

. prescribed or non-prescribed medical and disposable supplies that are not specifically identified under *Durable Medical Equipment Provider Services (DME)* and *Medical Supplies* in Section 5, *Additional Coverage Details*.

. Examples of supplies that are not covered include, but are not limited to:

* compression stockings, ace bandages, diabetic strips, and syringes;‍
* ostomy bags and related supplies; and
* urinary catheters.

This exclusion does not apply to:

* disposable supplies necessary for the effective use of Durable Medical Equipment Provider Services (DME) for which Benefits are provided as described under *Durable Medical Equipment Provider Services (DME)* in Section 5, *Additional Coverage Details*; or

. tubings, nasal cannulas, connectors and masks except when used with Durable Medical Equipment;

. the repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect; and

. the replacement of lost or stolen Durable Medical Equipment.

## ‍Mental Health, Neurobiological/Autism Spectrum Disorder/Substance-Related and Addictive Disorder Services

In addition to all other exclusions listed in this Section 8, *Exclusions and Limitations*, the exclusions listed directly below apply to services described under *Mental Health Services, Neurobiological/Autism Spectrum Disorder* and/or *Substance-Related and Addictive Disorder Services* in Section 5, *Additional Coverage Details*.

. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

. Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

. Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, pyromania, kleptomania, gambling disorder, and paraphilic disorder.

. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.

. Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with* *Disabilities Education Act.*

. Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

. Intensive behavioral therapies such as applied behavior analysis for Autism Spectrum Disorders.

. Non-Medical 24-Hour Withdrawal Management*.*

. High intensity residential care including *American Society of Addiction Medicine (ASAM)* criteria for Covered Persons with substance-related and addictive disorders who are unable to participate in their care due to significant cognitive impairment.

## Nutrition

. nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy;

. nutritional counseling, including non-specific disease nutritional education such as general good eating habits, calorie control or dietary preferences. This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement. This exclusion also does not apply to nutritional counseling services that are billed as *Preventive Care Services* or to medical or behavioral/mental health related nutritional education services that are provided as part of treatment for a disease by appropriately licensed or registered health care professionals when both of the following are true:

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

. Food of any kind, infant formula, standard milk-based formula, and donor breast milk. This exclusion does not apply to specialized enteral formula and other modified food products for which Benefits are provided as described under Enteral Nutrition in Section 5, Additional Coverage Details

. 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

. television;

. telephone;

. beauty/barber service;

. guest service;

. supplies, equipment and similar incidentals for personal comfort. Examples include:

* air conditioners;
* air purifiers and filters;
* batteries and battery chargers;
* dehumidifiers and humidifiers;
* ergonomically correct chairs;
* non-Hospital beds, comfort beds, motorized beds and mattresses;
* breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the *Health Resources and Services Administration (HRSA)* requirement;
* car seats;
* chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners;
* electric scooters;
* exercise equipment and treadmills;
* hot tubs, Jacuzzis, saunas and whirlpools;
* medical alert systems;
* music devices;
* personal computers;
* pillows;
* power-operated vehicles;
* radios;
* strollers;
* safety equipment;
* vehicle modifications such as van lifts;
* video players; and
* home modifications to accommodate a health need (including, but not limited to, ramps, swimming pools, elevators, handrails, and stair glides).

Physical Appearance

. Cosmetic Procedures, as defined in Section 13, *Glossary*, are excluded from coverage. Examples include:

* liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple, this exclusion does not apply to liposuction for which Benefits are provided as described under *Reconstructive Procedures* in Section 6, *Additional Coverage Details*;
* pharmacological regimens;
* nutritional procedures or treatments;
* tattoo or scar removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures);
* Sclerotherapy treatment of veins.
* 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; and
* varicose vein treatment of the lower extremities, when it is considered cosmetic;

. replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure;

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

. wigs regardless of the reason for the hair loss‍‍‍‍‍‍‍; and

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

## Procedures and Treatments

. biofeedback;

. 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);

. rehabilitation services‍ to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment;

. speech therapy to treat stuttering, stammering, or other articulation disorders;

. speech therapy, except when required for treatment of a speech impairment or speech dysfunction that results from Injury, stroke, cancer, a Congenital Anomaly or autism spectrum disorders as identified under *Speech Therapy* in Section 5, *Additional Coverage Details*;

. a procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy;

. excision or elimination of hanging skin on any part of the body (examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty);

. psychosurgery (lobotomy);

. stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings;

. chelation therapy, except to treat heavy metal poisoning;

. manipulative treatment to treat a condition unrelated to spinal manipulation and ancillary physiologic treatment rendered to restore/improve motion, reduce pain and improve function, such as asthma or allergies;

. manipulative treatment (the therapeutic application of chiropractic and osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function);

. 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;

. sex transformation operations and related services;

. the following treatments for obesity:

* non-surgical treatment, even if for morbid obesity; and
* surgical treatment of obesity even if there is a diagnosis of morbid obesity‍*‍*‍*‍*;

. medical and surgical treatment of hyperhidrosis (excessive sweating);

. services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), when the services are considered medical or dental in nature;

. Upper and lower jawbone surgery, orthognathic surgery and jaw alignment. This exclusion does not apply to reconstructive jaw surgery when there is a facial skeletal abnormality and associated functional medical impairment.

. breast reduction surgery except as coverage is required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Physicians Services - Reconstructive Surgery* in Section 5, *Additional Coverage Details;* and

. Intracellular micronutrient testing.

21. Cellular and Gene Therapy services not received from a Designated Provider.

## Providers

Services:

. performed by a provider who is a family member by birth or marriage, including your Spouse, brother, sister, parent or child;

. a provider may perform on himself or herself;

. performed by a provider with your same legal residence;

. ordered or delivered by a Christian Science practitioner;

. performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license;

. provided at a Freestanding Facility or diagnostic Hospital-based Facility without a written order from a provider;

. which are self-directed to a Freestanding Facility or diagnostic Hospital-based Facility; and

. ordered by a provider affiliated with a Freestanding Facility or diagnostic Hospital-based Facility, 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:
* Cryo-preservation and other forms of preservation of reproductive materials except as described under Infertility Services.
* Long-term storage (greater than one year) of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue.]
* Donor services and non-medical costs of oocyte or sperm donation such as donor agency fees.
* Embryo or oocyte accumulation defined as a fresh oocyte retrieval prior to the depletion of previously banked frozen embryos or oocytes.
* Natural cycle insemination in the absence of sexual dysfunction or documented congenital or acquired cervical disease or mild to moderate male factor.
* Ovulation predictor kits.

2. The following services related to a Gestational Carrier or Surrogate:

* Fees for the use of a Gestational Carrier or Surrogate.
* Insemination or InVitro fertilization procedures for Surrogate or transfer of an embryo to Gestational Carrier.
* Pregnancy services for a Gestational Carrier or Surrogate who is not a Covered Person.

3. Donor, Gestational Carrier or Surrogate administration, agency fees or compensation.

4. The following services related to donor services for donor sperm, ovum (egg cell) or oocytes (eggs), or embryos (fertilized eggs):

* Known egg donor (altruistic donation i.e., friend, relative or acquaintance) - The cost of donor eggs. Medical costs related to donor stimulation and egg retrieval. This refers to purchasing or receiving a donated egg that is fresh, or one that has already been retrieved and is frozen.
* Purchased egg donor (i.e., clinic or egg bank) – The cost of donor eggs. Medical costs related to donor stimulation and egg retrieval. This refers to purchasing a donor egg that has already been retrieved and is frozen or choosing a donor who will then undergo an egg retrieval once they have been selected in the database.
* Known donor sperm (altruistic donation i.e., friend, relative or acquaintance) – The cost of sperm collection, cryopreservation and storage. This refers to purchasing or receiving donated sperm that is fresh, or that has already been obtained and is frozen.
* Purchased donor sperm (i.e., clinic or sperm bank) – The cost of procurement and storage of donor sperm. This refers to purchasing donor sperm that has already been obtained and is frozen or choosing a donor from a database.

5. The reversal of voluntary sterilization.

6. Health care services and related expenses for surgical, non-surgical or drug-induced Pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage).

7. Contraceptive supplies and services.

8. Emergency contraceptives.

9. Assisted Reproductive Technology procedures done for non-genetic disorder sex selection or eugenic (selective breeding) purposes.

10. Infertility treatment with voluntary sterilization currently in place (vasectomy, bilateral tubal ligation).

11. Infertility treatment following unsuccessful reversal of voluntary sterilization.

12. Infertility treatment following the reversal of voluntary sterilization (tubal reversal/reanastomosis; vasectomy reversal/vasovasostomy or vasoepididymostomy).

13. Pre-implantation Genetic Testing for Aneuploidy (PGT-A) used to select embryos for transfer in order to increase the chance for conception.

## Services Provided under Another Plan

Services for which coverage is available:

. under another plan, except for Eligible Expenses payable as described in Section 9, *Coordination of Benefits (COB)*;

. under workers' compensation, no-fault automobile coverage or similar legislation if you could elect it, or could have it elected for you;

. while on active military duty; and

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

5. Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.

## Transplants

. health services for organ and tissue transplants, except as identified under *Organ/Tissue Transplants* in Section 5*, Additional Coverage Details* unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines;

. health services for transplants involving animal organs; and

.

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

**Travel**

. health services provided in a foreign country, unless required as Emergency Health Services; and

. Travel or transportation expenses, even if ordered by a Physician, except as identified under *Complex Medical Conditions Travel and Lodging Assistance Program* in Section 6, *Clinical Programs and Resources*. Additional travel expenses related to Covered Health Services received from a Designated Provider or other Network Provider may be reimbursed at the Plan’s discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in Section 5. *Additional Coverage Details*.

## Types of Care

. Custodial Care as defined in Section 13, *Glossary* or maintenance care;

. Domiciliary Care, as defined in Section 13, *Glossary;*

. multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain;

. Private Duty Nursing;

. respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under *Hospice Care* in Section 5, *Additional Coverage Details*;

. rest cures;

. services of personal care attendants;

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

## Vision and Hearing

. routine vision examinations, including refractive examinations to determine the need for vision correction;

. implantable lenses used only to correct a refractive error (such as Intacs corneal implants);

. purchase cost and associated fitting charges for eyeglasses or contact lenses;

. eye exercise or vision therapy; and

. 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

. autopsies and other coroner services and transportation services for a corpse;

. charges for:

* missed appointments;
* room or facility reservations;
* completion of claim forms; or
* record processing;

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

. diagnostic tests that are:

* delivered in 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;

. expenses for health services and supplies:

* that do not meet the definition of a Covered Health Service in Section 13, *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. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone;
* 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;
* that exceed Eligible Expenses or any specified limitation in this SPD;
* for which a provider waives the ‍‍‍‍ Coinsurance amounts;

6. foreign language and sign language services;

. Home Health Care Provider Services;

8. Pregnancy Benefits;

. Voluntary Sterilization;

. Cochlear Implant - Device and Surgery.

. Orthotic devices such as arm, leg, neck and back braces;

. long term (more than 30 days) storage of blood, umbilical cord or other material. Examples include cryopreservation of tissue, blood and blood products;

13. health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services the Plan would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.

For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

14. physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:

* required solely for purposes of education, sports or camp, travel, career or 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.

15. In the event a non-Network provider waives, does not pursue, or fails to collect, Copayments, Coinsurance and/or any deductible or other amount owed for a particular health care service, no Benefits are provided for the health care service when the Copayments, Coinsurance and/or deductible are waived, not pursued, or not collected.

# SECTION 8 - CLAIMS PROCEDURES

What this section includes:

* How ‍claims work.
* What to do if your claim is denied, in whole or in part.

When to Submit a Claim

If you receive a bill for Covered Health Services from a provider, you 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 your ID card.

## How to 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 Human Resources‍‍. 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.
* 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.
* A statement indicating either that you are, or you are not, enrolled for coverage under any other health plan or program. If you are enrolled for other coverage you must include the name and address of the other carrier(s).

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

For medical claims, the above information should be filed with UnitedHealthcare at the address on your ID card.‍

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

### Payment of Benefits

Except as required by the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260)*, you may not assign, transfer, or in any way convey your Benefits under the Plan or any cause of action related to your Benefits under the Plan to a provider or to any other third party. Nothing in this Plan shall be construed to make the Plan, Plan Sponsor, or Claims Administrator or its affiliates liable for payments to a provider or to a third party to whom you may be liable for payments for Benefits.  The Plan will not recognize claims for Benefits brought by a third party. Also, any such third party shall not have standing to bring any such claim independently, as a Covered Person or beneficiary, or derivatively, as an assignee of a Covered Person or beneficiary.  References herein to “third parties” include references to providers as well as any collection agencies or third parties that have purchased accounts receivable from providers or to whom accounts receivables have been assigned.

As a matter of convenience to a Covered Person, and where practicable for the Claims Administrator (as determined in its sole discretion), the Claims Administrator may make payment of Benefits directly to a provider.

Any such payment to a provider:

* is NOT an assignment of your Benefits under the Plan or of any legal or equitable right to institute any proceeding relating to your Benefits; and
* is NOT a waiver of the prohibition on assignment of Benefits under the Plan; and
* shall NOT estop the Plan, Plan Sponsor, or Claims Administrator from asserting that any purported assignment of Benefits under the Plan is invalid and prohibited.

If this direct payment for your convenience is made, the Plan’s obligation to you with respect to such Benefits is extinguished by such payment. If any payment of your Benefits is made to a provider as a convenience to you, the Claims Administrator will treat you, rather than the provider, as the beneficiary of your claim for Benefits, and the Plan reserves the right to offset any Benefits to be paid to a provider by any amounts that the provider owes the Plan (including amounts owed as a result of the assignment of other plans’ overpayment recovery rights to the Plan), pursuant to *Refund of Overpayments*in*Section 9: Coordination of Benefits*.

Eligible Expenses due to a non-Network provider for Covered Health Services that are subject to the *No Surprises Act of the Consolidated Appropriations Act* (*P.L. 116-260*) are paid directly to the provider.

### Form of Payment of Benefits

Payment of Benefits under the Plan shall be in cash or cash equivalents, or in the form of other consideration that UnitedHealthcare in its discretion determines to be adequate. Where Benefits are payable directly to a provider, such adequate consideration includes the forgiveness in whole or in part of amounts the provider owes to other plans for which UnitedHealthcare makes payments, where the Plan has taken an assignment of the other plans' recovery rights for value.

## 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 13, *Glossary*, for the definition of Explanation of Benefits.

Important - Timely Filing of ‍Claims

You should submit a request for payment of Benefits within 90 days after the date of service. 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, in ‍The Maryland National Capital Park and Planning Commission's discretion. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Claim Denials and Appeals

### If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, you may call UnitedHealthcare at the number on your ID card before requesting a formal appeal. If UnitedHealthcare cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

### How to Appeal a Denied Claim

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. This communication should include:

* The patient's name and ID number as shown on the ID card.
* The provider's name.
* The date of medical service.
* The reason you disagree with the denial.
* Any documentation or other written information to support your request.

You or your authorized representative may send a written request for an appeal to:

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

For urgent care requests for Benefits that have been denied, you or your provider can call UnitedHealthcare at the toll-free number on your ID card to request an appeal.

Types of claims

The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:

* Urgent care request for Benefits.
* Pre-service request for Benefits.
* Post-service claim.
* Concurrent claim.

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. If your situation is urgent, your review will be conducted as quickly as possible. If you believe your situation is urgent, you may request an expedited review, and, if applicable, file an external review at the same time. For help call the Claims Administrator at the number listed on your health plan ID card. Generally, an urgent situation is when your life or health may be in serious jeopardy. Or when, in the opinion of your doctor, you may be experiencing severe pain that cannot be adequately controlled while you wait for a decision on your claim or appeal.

### Review of an Appeal

UnitedHealthcare will conduct a full and fair review of your appeal. The appeal may be reviewed by:

* An appropriate individual(s) who did not make the initial benefit determination.
* A health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

### Filing a Second Appeal

Your‍ Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from UnitedHealthcare within 60 days from receipt of the first level appeal determination.

***Note***: Upon written request and free of charge, any Covered Persons may examine their claim and/or appeals file(s). Covered Persons may also submit evidence, opinions and comments as part of the internal claims review process. UnitedHealthcare will review all claims in accordance with the rules established by the *U.S. Department of Labor*. Any Covered Person will be automatically provided, free of charge, and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required, with: (i) any new or additional evidence considered, relied upon or generated by the Plan in connection with the claim; and, (ii) a reasonable opportunity for any Covered Person to respond to such new evidence or rationale.

##  External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by ‍UnitedHealthcare, or if ‍UnitedHealthcare fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of ‍ UnitedHealthcare’s determination. The process is available at no charge to you.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

* Clinical reasons.
* The exclusions for Experimental or Investigational Service(s) or Unproven Service(s).
* Rescission of coverage (coverage that was cancelled or discontinued retroactively).
* As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the number on your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received ‍UnitedHealthcare’s decision.

An external review request should include all of the following:

* A specific request for an external review.
* The Covered Person's name, address, and insurance ID number.
* Your designated representative's name and address, when applicable.
* The service that was denied.
* Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). UnitedHealthcare has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:

* A standard external review.
* An expedited external review.

Standard External Review

A standard external review is comprised of all of the following:

* A preliminary review by UnitedHealthcare of the request.
* A referral of the request by UnitedHealthcare to the IRO.
* A decision by the IRO.

Within the applicable timeframe after receipt of the request, UnitedHealthcare will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

* Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
* Has exhausted the applicable internal appeals process.
* Has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the preliminary review, UnitedHealthcare will issue a notification in writing to you. If the request is eligible for external review, UnitedHealthcare will assign an IRO to conduct such review. UnitedHealthcare will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

The *IRO* will notify you in writing of the request’s eligibility and acceptance for external review and if necessary, for any additional information needed to conduct the external review. You will generally have to submit the additional information in writing to the *IRO* within ten business days following the date you receive the *IRO*’s request for the additional information. The *IRO* is not required to, but may, accept and consider additional information submitted by you after ten business days.

UnitedHealthcare will provide to the assigned IRO the documents and information considered in making ‍UnitedHealthcare’s determination. The documents include:

* All relevant medical records.
* All other documents relied upon by ‍UnitedHealthcare.
* All other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request and UnitedHealthcare will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim as new and not be bound by any decisions or conclusions reached by ‍UnitedHealthcare. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and UnitedHealthcare, and it will include the clinical basis for the determination.

Upon receipt of a *Final External Review Decision* reversing ‍UnitedHealthcare's determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the *Final External Review Decision* agrees with ‍UnitedHealthcare’s determination, the Plan will not be obligated to provide Benefits for the health care service or procedure.

### Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

* An adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal.
* A final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, UnitedHealthcare will determine whether the individual meets both of the following:

* Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
* Has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the review, UnitedHealthcare will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, UnitedHealthcare will assign an IRO in the same manner UnitedHealthcare utilizes to assign standard external reviews to IROs. UnitedHealthcare will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim as new and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to UnitedHealthcare.

You may contact UnitedHealthcare at the toll-free number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

### Timing of Appeals Determinations

Separate schedules apply to the timing of claims appeals, depending on the type of claim. There are three types of claims:

* Urgent care request for Benefits - a request for Benefits provided in connection with urgent care services.
* Pre-Service request for Benefits - a request for Benefits which the Plan must approve or in which you must notify UnitedHealthcare before non-urgent care is provided.
* Post-Service - a claim for reimbursement of the cost of non-urgent care that has already been provided.

Please note that the decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure.

You may have the right to external review through an *Independent Review Organization* *(IRO)* upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in the Claims Administrator's decision letter to you.

The tables below describe the time frames which you and UnitedHealthcare are required to follow.

| Urgent Care Request for Benefits\* |
| --- |
| Type of Request for Benefits or Appeal | Timing |
| If your request for Benefits is incomplete, UnitedHealthcare must notify you within: | **24 hours** |
| You must then provide completed request for Benefits to UnitedHealthcare within: | **48 hours** after receiving notice of additional information required |
| UnitedHealthcare must notify you of the benefit determination within: | **72 hours** |
| If UnitedHealthcare denies your request for Benefits, you must appeal an adverse benefit determination no later than: | **180 days** after receiving the adverse benefit determination |
| UnitedHealthcare must notify you of the appeal decision within: | **72 hours** after receiving the appeal |
| \*You do not need to submit urgent care appeals in writing. You should call UnitedHealthcare as soon as possible to appeal an urgent care request for Benefits. |

| Pre-Service Request for Benefits\* |
| --- |
| Type of Request for Benefits or Appeal | Timing |
| If your request for Benefits is filed improperly, UnitedHealthcare must notify you within: | **5 days** |
| If your request for Benefits is incomplete, UnitedHealthcare must notify you within: | **15 days** |
| You must then provide completed request for Benefits information to UnitedHealthcare within: | **45 days** |
| UnitedHealthcare must notify you of the benefit determination: |
| * if the initial request for Benefits is complete, within:
 | **15 days** |
| * after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:
 | **15 days** |
| You must appeal an adverse benefit determination no later than: | **180 days** after receiving the adverse benefit determination |
| UnitedHealthcare must notify you of the first level appeal decision within: | **15 days** after receiving the first level appeal |
| You must appeal the first level appeal (file a second level appeal) within: | **60 days** after receiving the first level appeal decision |
| UnitedHealthcare must notify you of the second level appeal decision within: | **15 days** after receiving the second level appeal |
| \*UnitedHealthcare may require a one-time extension for the initial claim determination, of no more than 15 days, only if more time is needed due to circumstances beyond control of the Plan. |

| Post-Service Claims |
| --- |
| Type of Claim or Appeal | Timing |
| If your claim is incomplete, UnitedHealthcare must notify you within: | **30 days** |
| You must then provide completed claim information to UnitedHealthcare within: | **45 days** |
| UnitedHealthcare must notify you of the benefit determination: |
| * if the initial claim is complete, within:
 | **30 days** |
| * after receiving the completed claim (if the initial claim is incomplete), within:
 | **30 days** |
| You must appeal an adverse benefit determination no later than: | **180 days** after receiving the adverse benefit determination |
| UnitedHealthcare must notify you of the first level appeal decision within: | **30 days** after receiving the first level appeal |
| You must appeal the first level appeal (file a second level appeal) within: | **60 days** after receiving the first level appeal decision |
| UnitedHealthcare must notify you of the second level appeal decision within: | **30 days** after receiving the second level appeal |

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent care request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. UnitedHealthcare will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent care request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

## Limitation of Action

You cannot bring any legal action against The Maryland National Capital Park and Planning Commission 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 Maryland National Capital Park and Planning Commission 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 Maryland National Capital Park and Planning Commission or the Claims Administrator.

You cannot bring any legal action against The Maryland National Capital Park and Planning Commission 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 Maryland National Capital Park and Planning Commission or the Claims Administrator you must do so within three years of the date you are notified of the final decision on your appeal or you lose any rights to bring such an action against The Maryland National Capital Park and Planning Commission or the Claims Administrator.

# SECTION 9 - 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.
* Procedures in the event the Plan overpays Benefits.

**Benefits When You Have Coverage under More than One Plan**

This section describes how Benefits under the Plan will be coordinated with those of any other plan that provides benefits to you.

**When Does Coordination of Benefits Apply?**

This *Coordination of Benefits (COB)* provision 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.
* 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. How much this Plan will reimburse you, if anything, will also depend in part on the Allowable Expense. The term, “Allowable Expense,” is further explained below.

**What Are the Rules for Determining the Order of Benefit Payments?**

***Order of Benefit Determination Rules***

The order of benefit determination rules determine whether this Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When this Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When this Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

The order of benefit determination rules below govern the order in which each Plan will pay a claim for benefits.

* **Primary Plan.** The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses.
* **Secondary Plan.** The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense. Allowable Expense is defined below.

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

1. This Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy.
2. 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.
3. Each Plan determines its order of benefits using the first of the following rules that apply:

1. **Non-Dependent or Dependent**. The Plan that covers the person other than as a dependent, for example as an employee, former employee under COBRA, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.

2. **Dependent Child Covered Under More Than One Coverage Plan.** Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

1. For a dependent child whose parents are married or are living together, whether or not they have ever been married:
2. The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
3. If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.
4. For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:
5. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary Plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.
6. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.
7. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.
8. If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:
	1. The Plan covering the Custodial Parent.
	2. The Plan covering the Custodial Parent's spouse.
	3. The Plan covering the non-Custodial Parent.
	4. The Plan covering the non-Custodial Parent's spouse.

For purpose of this section, Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

1. For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.
2. (i) For a dependent child who has coverage under either or both parents’ plans and also has his or her own coverage as a dependent under a spouse’s plan, the rule in paragraph (5) applies.

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

3. **Active Employee or Retired or Laid-off Employee.** The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled C.1. can determine the order of benefits.

4. **COBRA or State Continuation Coverage.** If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled C.1. can determine the order of benefits.

5. **Longer or Shorter Length of Coverage.** The Plan that covered the person the longer period of time is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

6. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the Primary Plan.

**How Are Benefits Paid When This Plan is Secondary?**

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

* The Plan determines the amount it would have paid based on the Allowable expense.
* The Plan pays the entire difference between the Allowable Expense and the amount paid by the Primary Plan, as long as this amount is not more than the Plan would have paid had it been the only plan involved.

You will be responsible for any applicable Copayment, Coinsurance or Deductible payments as part of the COB payment. The maximum combined payment you may receive from all plans cannot exceed 100% of the Allowable Expense.

**How is the Allowable Expense Determined when this Plan is Secondary?**

***Determining the Allowable Expense If this Plan is Secondary***

What is an Allowable Expense? For purposes of COB, an Allowable Expense is a health care expense that is covered at least in part by one of the health benefit plans covering you.

When the provider is a Network provider for both the Primary Plan and this Plan, the Allowable Expense is the Primary Plan’s network rate. When the provider is a network provider for the Primary Plan and a non-Network provider for this Plan, the Allowable Expense is the Primary Plan’s network rate. When the provider is a non-Network provider for the Primary Plan and a Network provider for this Plan, the Allowable Expense is the reasonable and customary charges allowed by the Primary Plan. When the provider is a non-Network provider for both the Primary Plan and this Plan, the Allowable Expense is the greater of the two Plans’ reasonable and customary charges. If this plan is secondary to Medicare, please also refer to the discussion in the section below, titled “Determining the Allowable Expense When this Plan is Secondary to Medicare”.

**What is Different When You Qualify for Medicare?**

***Determining Which Plan is Primary When You Qualify for Medicare***

As 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 (however, Domestic Partners are excluded as provided by Medicare).
* Individuals with end-stage renal disease, for a limited period of time.
* Disabled individuals under age 65 with current employment status and their Dependents under age 65.

***Determining the Allowable Expense When this Plan is Secondary to Medicare***

If this Plan is secondary to Medicare, the Medicare approved amount is the Allowable Expense, as long as the provider accepts reimbursement directly from Medicare. If the provider accepts reimbursement directly from Medicare, the Medicare approved amount is the charge that Medicare has determined that it will recognize and which it reports on an "explanation of Medicare benefits" issued by Medicare (the "EOMB") for a given service. Medicare typically reimburses such providers a percentage of its approved charge – often 80%.

If the provider does not accept assignment of your Medicare benefits, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare – typically 115% of the Medicare approved amount) will be the Allowable Expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the Allowable Expense.

If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, or if you have enrolled in Medicare but choose to obtain services from an Opt-out provider or one that does not participate in the Medicare program or a provider who does not accept assignment of Medicare benefits, Benefits will be paid on a secondary basis under this Plan and will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider.

When calculating the Plan's Benefits in these situations, and when Medicare does not issue an EOMB, for administrative convenience the Claims Administrator will use the provider’s billed charges for covered services as the Allowable Expense for both the Plan and Medicare.

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

* The Plan determines the amount it would have paid had it been the only plan involved.
* The Plan pays the entire difference between the Allowable Expense and the amount paid by the Primary Plan – as long as this amount is not more than the Plan would have paid had it been the only plan involved.

The maximum combined payment you may receive from all plans cannot exceed 100% of the applicable Allowable Expense.

**Medicare Crossover Program**

The Plan offers a Medicare Crossover program for Medicare Part A and Part B and Durable Medical Equipment (DME) claims. Under this program, you no longer have to file a separate claim with the Plan to receive secondary benefits for these expenses. Your Dependent will also have this automated Crossover, as long as he or she is eligible for Medicare and this Plan is your only secondary medical coverage.

Once the Medicare Part A and Part B and DME carriers 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.

You can verify that the automated crossover took place when your copy of the explanation of Medicare benefits (EOMB) states your claim has been forwarded to your secondary carrier.

This crossover process does not apply to 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 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 Claims 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 Claims 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 the Claims Administrator any facts needed to apply those rules and determine benefits payable. If you do not provide the Claims Administrator the information needed to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

**Does This Plan Have the Right of Recovery?**

***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 the Plan 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 Plan Sponsor may recover the amount in the form of salary, wages, or benefits payable under any Plan Sponsor-funded benefit plans, including this Plan. The Plan Sponsor 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, the Claims Administrator reserves the right to recover the excess amount from the provider pursuant to Refund of Overpayments, below.

***Refund of Overpayments***

If the Plan 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 Plan if:

* The Plan’s obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid by you, but all or some of the expenses were not paid by you or did not legally have to be paid by you.
* All or some of the payment the Plan made exceeded the Benefits under the Plan.
* All or some of the payment was made in error.

The amount that must be refunded equals the amount the Plan paid in excess of the amount that should have been paid under the Plan. If the refund is due from another person or organization, you agree to help the Plan get the refund when requested.

If the refund is due from you and you do not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Benefits for you that are payable under the Plan. If the refund is due from a person or organization other than you, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Plan; or (ii) future Benefits that are payment in connection with services provided to persons under other plans for which the Claims Administrator processes payments, pursuant to a transaction in which the Plan’s overpayment recovery rights are assigned to such other plans in exchange for such plans’ remittance of the amount of the reallocated payment. The reallocated payment amount will either:

* equal the amount of the required refund, or
* if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan.

The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

# SECTION 10 - SUBROGATION AND REIMBURSEMENT

The Plan has a right to subrogation and reimbursement. References to "you" or "your" in this Subrogation and Reimbursement section shall include you, your estate and your heirs and beneficiaries unless otherwise stated.

Subrogation applies when the plan has paid Benefits on your behalf for a Sickness or Injury for which any third party is allegedly to be responsible. The right to subrogation means that 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 the Benefits that the Plan has paid that are related to the Sickness or Injury for which any third party is considered responsible.

*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.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for 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 receive for that Sickness or Injury. The right of reimbursement shall apply to any Benefits received at any time until the rights are extinguished, resolved or waived in writing.

*Reimbursement - Example*

Suppose you are injured in a boating accident that is not your fault, and you receive Benefits under the Plan as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the plan 100% of any Benefits you received to treat your injuries.

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 alleged to have caused or who caused the Sickness, Injury or damages.
* The Plan Sponsor in a workers' compensation case or other matter alleging liability.
* Any person or entity who is or may be obligated to provide Benefits or payments to you, including Benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
* Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a Sickness or Injury you allege or could have alleged were the responsibility of any third party.
* Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

* You will cooperate with the Plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
* 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.
* Providing any relevant information requested by the Plan.
* Signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim.
* Responding to requests for information about any accident or injuries.
* Making court appearances.
* Obtaining the Plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses.
* Complying with the terms of this section.

Your failure to cooperate with the Plan 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 alleged to have been caused or 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 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 will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

* The Plan has a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
* 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, your estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. 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, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.
* Benefits paid by the Plan may also be considered to be Benefits advanced.
* If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
* By participating in and accepting Benefits from the Plan, you agree that (i) any amounts recovered by you from any third party shall constitute Plan assets to the extent of the amount of Plan Benefits provided on behalf of the Covered Person, (ii) you and your representative shall be fiduciaries of the Plan (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the Plan to enforce its reimbursement rights.
* The Plan's rights to recovery will not be reduced due to your own negligence.
* By participating in and accepting Benefits from the Plan, you agree to assign to the Plan any Benefits, claims or rights of recovery you have under any automobile policy - including no-fault Benefits, PIP Benefits and/or medical payment Benefits - other coverage or against any third party, to the full extent of the Benefits the Plan has paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting Benefits, you acknowledge and recognize the Plan's right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.
* The Plan may, at its option, take necessary and appropriate action to preserve its rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical Benefits you receive for the Sickness or Injury out of any settlement, judgment or other recovery from any third party considered responsible and filing suit in your name or your estate's name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund Benefits as required under the terms of the Plan is governed by a six-year statute of limitations.
* You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
* The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
* In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death the Plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.
* No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
* 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 any 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.
* If a third party causes or is alleged to have caused 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 covered.
* In the event that you do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate Benefits to you, your dependents or the participant, 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 alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to your failure to abide by the terms of the Plan. 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 will also be required to pay interest on any amounts you hold which should have been returned to the Plan.
* The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Right of Recovery

The Plan also 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.

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.
* Reduce a future Benefit payment for you or your Dependent by the amount of the overpayment.

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.
* Conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

# SECTION 11 - WHEN COVERAGE ENDS

What this section includes:

* Circumstances that cause coverage to end.
* Conversion from a group policy to an individual policy.
* 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 Maryland National Capital Park and Planning Commission 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 ‍last day of the month‍ your employment with the Company ends.
* The date the Plan ends.
* The ‍last day of the month‍ you stop making the required contributions.
* The ‍last day of the month‍ you are no longer eligible.
* The ‍last day of the month‍ UnitedHealthcare receives written notice from The Maryland National Capital Park and Planning Commission to end your coverage, or the date requested in the notice, if later.
* The ‍last day of the month‍ you retire or are pensioned under the Plan, unless specific coverage is available for retired or pensioned persons and you are eligible for that coverage.

Coverage for your eligible Dependents will end on the earliest of:

* The date your coverage ends.
* The ‍last day of the month‍ you stop making the required contributions.
* The ‍last day of the month‍ UnitedHealthcare receives written notice from The Maryland National Capital Park and Planning Commission to end your coverage, or the date requested in the notice, if later.
* The ‍last day of the month‍ your Dependents no longer qualify as Dependents under this Plan.

Other Events Ending Your Coverage

The Plan will provide at least thirty days' 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, knowingly providing incorrect information relating to another person's eligibility or status as a Dependent. You may appeal this decision during the 30-day notice period. The notice will contain information on how to pursue your appeal.

***Note***: If UnitedHealthcare and The Maryland National Capital Park and Planning Commission find that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact, The Maryland National Capital Park and Planning Commission has the right to demand that you pay back all Benefits The Maryland National Capital Park and Planning Commission paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.

## Coverage for a Disabled Dependent Child

Coverage for an unmarried enrolled Dependent child who is disabled will not end just because the child has reached a certain age. The Plan will extend the coverage for that child beyond the limiting age if both of the following are true regarding the enrolled Dependent child:

* Is not able to be self-supporting because of mental, developmental, or physical disability.
* Depends mainly on you for support.

Coverage will continue as long as the enrolled Dependent is medically certified as disabled and dependent unless coverage is otherwise terminated in accordance with the terms of the Plan.

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

The Plan may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical examinations at the Plan's expense. However, the Plan will not ask for this information more than once a year.

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

## Continuing Coverage Through COBRA

If you lose your Plan coverage, you may have the right to extend it under the *Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)*, as defined in Section 13, *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 Maryland National Capital Park and Planning Commission 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.
* A Participant's former Spouse.

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 | 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 coverage1 | 29 months | 29 months | 29 months |
| You die | N/A | 36 months | 36 months |
| You divorce (or legally separate) | N/A | 36 months | 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 below | See table below |
| The Maryland National Capital Park and Planning Commission files for bankruptcy under Title 11, United States Code.2 | 36 months | 36 months3 | 36 months3 |

1Subject 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 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.

2This is a qualifying event for any Retired Participant and his or her enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

3From the date of the Participant's death if the Participant dies during the continuation coverage.

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.
* 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, 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 or an enrolled Dependent's loss of eligibility as an enrolled Dependent.
* The date your enrolled Dependent would lose coverage under the Plan.
* 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 Human Resources‍‍ 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 at the address stated in Section 14, *Important Administrative Information‍*. 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, on the earliest of the following dates:

* The date, after electing continuation coverage, that coverage is first obtained under any other group health plan.
* The date, after electing continuation coverage, that you or your covered Dependent first becomes entitled to Medicare.
* The date coverage ends for failure to make the first required premium payment (premium is not paid within 45 days).
* The date coverage ends for failure to make any other monthly premium payment (premium is not paid within 30 days of its due date).
* The date the entire Plan ends.
* The date 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.
* 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).
* Covered under or eligible for any group, individual, prepayment, government, or other plan or program which would result in over insurance 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.
* 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 12 - OTHER IMPORTANT INFORMATION

What this section includes:

* Court-ordered Benefits for Dependent children.
* Your relationship with UnitedHealthcare and The Maryland National Capital Park and Planning Commission.
* Relationships with providers.
* Interpretation of Benefits.
* Review and Determine Benefits in Accordance with UnitedHealthcare Reimbursement Policies.
* Information and records.
* .
* The future of the Plan.
* 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 Maryland National Capital Park and Planning Commission

In order to make choices about your health care coverage and treatment, The Maryland National Capital Park and Planning Commission 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 Maryland National Capital Park and Planning Commission 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 SPD.
* 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 Maryland National Capital Park and Planning Commission 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 Maryland National Capital Park and Planning Commission and UnitedHealthcare will use individually identifiable information about you as permitted or required by law, including in operations and in research. The Maryland National Capital Park and Planning Commission and UnitedHealthcare will use de-identified data for commercial purposes including research.

## Relationship with Providers

The Claims Administrator has agreements in place that govern the relationships between it and The Maryland National Capital Park and Planning Commission and Network providers, some of which are affiliated providers. Network providers enter into agreements with the Claims Administrator to provide Covered Health Services to Covered Persons.

The Maryland National Capital Park and Planning Commission and UnitedHealthcare do not provide health care services or supplies, nor do they practice medicine. Instead, The Maryland National Capital Park and Planning Commission and UnitedHealthcare arrange for health care providers to participate in a Network and administer payment of Benefits. 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 Maryland National Capital Park and Planning Commission’s employees nor are they employees of UnitedHealthcare. The Maryland National Capital Park and Planning Commission and UnitedHealthcare are not responsible 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 Maryland National Capital Park and Planning Commission is solely responsible for:

* Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
* The timely payment of the service fee to UnitedHealthcare.
* The funding of Benefits on a timely basis.

Notifying you of the termination or modifications to the Plan

Your Relationship with Providers

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

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

The relationship between you and The Maryland National Capital Park and Planning Commission is that of employer and employee, Dependent or other classification as defined in the SPD.

**Interpretation of Benefits**

The Maryland National Capital Park and Planning Commission and UnitedHealthcare have the sole and exclusive discretion to do all of the following:

* Interpret Benefits under the Plan.
* Interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD, the Schedule of Benefits and any Addendums, SMMs and/or Amendments.
* Make factual determinations related to the Plan and its Benefits.

The Maryland National Capital Park and Planning Commission and UnitedHealthcare may delegate this discretionary authority to other persons or entities including Claims Administrator’s affiliates that may provide services in regard to the administration of the Plan. The identity of the service providers and the nature of their services may be changed from time to time in Plan Sponsor's and the Claims Administrator's discretion. In order to receive Benefits, you must cooperate with those service providers.

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

Review and Determine Benefits in Accordance with UnitedHealthcare Reimbursement Policies

UnitedHealthcare develops its reimbursement policy guidelines, in its sole discretion, in accordance with one or more of the following methodologies:

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

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), UnitedHealthcare's reimbursement policies are applied to provider billings. UnitedHealthcare shares it's reimbursement policies with Physicians and other providers in UnitedHealthcare's Network through UnitedHealthcare's provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by UnitedHealthcare's reimbursement policies) and the billed charge. However, non-Network providers are not subject to this prohibition, and may bill you for any amounts the Plan does not pay, including amounts that are denied because one of UnitedHealthcare's reimbursement policies does not reimburse (in whole or in part) for the service billed. You may obtain copies of UnitedHealthcare's reimbursement policies for yourself or to share with your non-Network Physician or provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.

UnitedHealthcare may apply a reimbursement methodology established by *OptumInsight* and/or a third party vendor, which is based on *CMS* coding principles, to determine appropriate reimbursement levels for Emergency Health Care Services. The methodology is usually based on elements reflecting the patient complexity, direct costs, and indirect costs of an Emergency Health Care Service. If the methodology(ies) currently in use become no longer available, UnitedHealthcare will use a comparable methodology(ies). UnitedHealthcare and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to UnitedHealthcare's website at **www.myuhc.com** for information regarding the vendor that provides the applicable methodology

## Information and Records

The Maryland National Capital Park and Planning Commission 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 Maryland National Capital Park and Planning Commission and UnitedHealthcare may request additional information from you to decide your claim for Benefits. The Maryland National Capital Park and Planning Commission and UnitedHealthcare will keep this information confidential. The Maryland National Capital Park and Planning Commission 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 Maryland National Capital Park and Planning Commission and UnitedHealthcare with all information or copies of records relating to the services provided to you, including provider billing and provider payment records. The Maryland National Capital Park and Planning Commission 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 Maryland National Capital Park and Planning Commission and UnitedHealthcare agree that such information and records will be considered confidential.

The Maryland National Capital Park and Planning Commission 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 Maryland National Capital Park and Planning Commission is required to do by law or regulation. During and after the term of the Plan, The Maryland National Capital Park and Planning Commission 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 Maryland National Capital Park and Planning Commission 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, as permitted by law, The Maryland National Capital Park and Planning Commission 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. UnitedHealthcare's 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, surveys, discount programs and/or programs to seek care in a more cost effective setting and/or from Designated Providers. In some instances, these programs may be offered in combination with a non-UnitedHealthcare entity. The decision about whether or not to participate is yours alone but The Maryland National Capital Park and Planning Commission 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 your ID card if you have any questions. Additional information may be found in Section 7, *Clinical Programs and Resources*.

## Rebates and Other Payments

The Maryland National Capital Park and Planning Commission 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.‍ The Maryland National Capital Park and Planning Commission and UnitedHealthcare may pass a portion of these rebates on to you. When rebates are passed on to you, they may be taken into account in determining your ‍‍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 Company 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 Company'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 Company 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 Company 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 Company and others as may be required by any applicable law.

## Plan Document

This Summary Plan Description (SPD) represents an overview of your Benefits. In the event there is a discrepancy between the SPD 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.

## Medicare Eligibility

Benefits under the Plan are not intended to supplement any coverage provided by Medicare. Nevertheless, in some circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled under the Plan.

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

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Plan), you should enroll in and maintain coverage under both Medicare Part A and Part B‍‍. If you don't enroll and maintain that coverage, and if the Plan is the secondary payer as described in Section 9, *Coordination of Benefits*, the Plan will pay Benefits under the Plan as if you were covered under both Medicare Part A and Part B‍‍. As a result, you will be responsible for the costs that Medicare would have paid and you will incur a larger out-of-pocket cost.

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

# SECTION 13 - GLOSSARY

What this section includes:

* Definitions of terms used throughout this SPD.

Many of the terms used throughout this SPD 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 SPD, 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 SPD and any amendments thereto shall apply to the Addendum except that in the case of any conflict between the Addendum and SPD and/or Amendments to the SPD, the Addendum shall be controlling.

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

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

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

An Alternate Facility may also provide Mental Health Services or Substance-Related and Addictive Disorder Services on an outpatient basis or inpatient basis (for example a Residential Treatment facility).

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.

**Ancillary Services** – items and services provided by non-Network Physicians at a Network facility that are any of the following:

* Related to emergency medicine, anesthesiology, pathology, radiology, and neonatology;
* Provided by assistant surgeons, hospitalists, and intensivists;
* Diagnostic services, including radiology and laboratory services, unless such items and services are excluded from the definition of Ancillary Services as determined by the Secretary;
* Provided by such other specialty practitioners as determined by the Secretary; and
* Provided by a non-Network Physician when no other Network Physician is available.

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

Benefits - Plan payments for Covered Health Services, subject to the terms and conditions of the Plan and any Addendums and/or Amendments.

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

Cancer Resource Services (CRS) - a program administered by UnitedHealthcare or its affiliates made available to you by The Maryland National Capital Park and Planning Commission. The CRS program provides:

* Specialized consulting services, on a limited basis, to Participants and enrolled Dependents with cancer.
* Access to cancer centers with expertise in treating the most rare or complex cancers.
* Education to help patients understand their cancer and make informed decisions about their care and course of treatment.

CHD - see Congenital Heart Disease (CHD).

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 charge, stated as a percentage of Eligible Expenses or the Recognized Amount when applicable, that you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works.*

 Company - The Maryland National Capital Park and Planning Commission.

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.
* 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.

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

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

Covered Health Services - those health services, including services or supplies, which the Claims Administrator determines to be:

* Provided for the purpose of preventing, evaluating, diagnosing or treating Sickness, Injury, Mental Illness, Substance-Related and Addictive Disorder Services, condition, disease, or their symptoms.
* Included in Section 4, Plan Highlights and Section 5, Additional Coverage Details.
* Provided to a Covered Person who meets the Plan's eligibility requirements, as described under *Eligibility* in Section 2, *Introduction*.
* Not identified in Section 7, *Exclusions and Limitations*.

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 your ID card. This information is available to Physicians and other health care professionals on **www.UHCprovider.com**.

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

CRS - see Cancer Resource Services (CRS).

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

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

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

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 Dispensing Entity** - a pharmacy, provider, or facility that has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to provide Pharmaceutical Products for the treatment of specified diseases or conditions. Not all Network pharmacies, providers, or facilities are Designated Dispensing Entities.

**Designated Network Benefits** - the description of how Benefits are paid for certain Covered Health Services provided by a provider or facility that has been identified as a Designated Provider. The Schedule of Benefits table in Section 4, *Plan Highlights* will tell you if your plan offers Designated Network Benefits and how they apply.

Designated Provider - a provider and/or facility that:

* Has entered into an agreement with UnitedHealthcare, or with an organization contracting on UnitedHealthcare's behalf, to provide Covered Health Services for the treatment of specific diseases or conditions; or
* UnitedHealthcare has identified through UnitedHealthcare's designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures.

A Designated Provider may or may not be located within your geographic area. Not all Network Hospitals or Network Physicians are Designated Providers.

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

Designated Physician - a Physician that the Claims Administrator identified through its designation programs as a Designated provider. A Designated Physician may or may not be located within your geographic area. The fact that a Physician is a Network Physician does not mean that he or she is a Designated Physician.

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

DME - see Durable Medical Equipment (DME).

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

Domestic Partnership - a relationship between a Participant and one other person of the same or opposite sex. All of the following requirements apply to both persons:

* They must not be related by blood or a degree of closeness that would prohibit marriage in the law of the state in which they reside.
* They must not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
* They must be at least 18 years old.
* They must share the same permanent residence and the common necessities of life.
* They must be mentally competent to enter into a contract.
* They must be financially interdependent.

The Participant and Domestic Partner must jointly sign an affidavit of domestic partnership provided by Human Resources‍‍ upon your request.

**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:

* Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
* Is not disposable.
* Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
* Can withstand repeated use.
* Is not implantable within the body.
* Is appropriate for use, and is primarily used, within the home.

Eligible Expenses - for Covered Health Services, incurred while the Plan is in effect, Eligible Expenses are determined by UnitedHealthcare as stated below and as detailed in Section 3, *How the Plan Works*.

Eligible Expenses are determined in accordance with UnitedHealthcare's reimbursement policy guidelines. UnitedHealthcare develops the reimbursement policy guidelines, in UnitedHealthcare's discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

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

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

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

Emergency Health Services -

with respect to an Emergency:

* An appropriate medical screening examination (as required under section *1867 of the Social Security Act, 42 U.S.C. 1395dd*or as would be required under such section if such section applied to an Independent Freestanding Emergency Department*)*that is within the capability of the emergency department of a Hospital, or an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency.
* Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital or an Independent Freestanding Emergency Department, as applicable, as are required under section *1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3))*, or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further exam or treatment is provided). For the purpose of this definition, “to stabilize” has the meaning as given such term in section *1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).*
* Emergency Health Services include items and services otherwise covered under the Plan when provided by a non-Network provider or facility (regardless of the department of the Hospital in which the items are services are provided) after the patient is stabilized and as part of outpatient observation, or as a part of an Inpatient Stay or outpatient stay that is connected to the original Emergency unless the following conditions are met:
1. The attending Emergency Physician or treating provider determines the patient is able to travel using nonmedical transportation or non-Emergency medical transportation to an available Network provider or facility located within a reasonable distance taking into consideration the patient's medical condition.
2. The provider furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law.
3. The patient is in such a condition, as determined by the Secretary, to receive information as stated in b) above and to provide informed consent in accordance with applicable law.
4. The provider or facility satisfies any additional requirements or prohibitions as may be imposed by state law.
5. Any other conditions as specified by the Secretary.

The above conditions do not apply to unforeseen or urgent medical needs that arise at the time the service is provided regardless of whether notice and consent criteria has been satisfied.

Employee Retirement Income Security Act of 1974 (ERISA) - the federal legislation that regulates retirement and employee welfare benefit programs maintained by employers and unions.

Employer - The Maryland National Capital Park and Planning Commission.

EOB - see Explanation of Benefits (EOB).

Experimental or Investigational Service(s) - medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time the Claims Administrator‍ and The Maryland National Capital Park and Planning Commission make 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 as appropriate for the proposed use in any of the following:
* *AHFS Drug Information (AHFS DI)* under therapeutic uses section;
* *Elsevier Gold Standard's Clinical Pharmacology* under the indications section;
* *DRUGDEX System by Micromedex* under the therapeutic uses section and has a strength recommendation rating of class I, class IIa, or class IIb*;* or
* *National Comprehensive Cancer Network (NCCN)* drugs and biologics compendium category of evidence 1, 2A, or 2B.
* 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.)
* The subject of an ongoing Clinical Trial that meets the definition of a Phase I, II or III Clinical Trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.
* Only obtainable, with regard to outcomes for the given indication, within research settings.

Exceptions:

* Clinical Trials for which Benefits are available as described under *Clinical Trials* in Section 5, *Additional Coverage Details*.
* If you are not a participant in a qualifying Clinical Trial as described under Section 5, *Additional Coverage Details,* and have a Sickness or condition that is likely to cause death within one year of the request for treatment, the Claims Administrator and The Maryland National Capital Park and Planning Commission may, at their discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, the Claims Administrator and The Maryland National Capital Park and Planning Commission 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.
* Coinsurance.
* Any other reductions taken.
* The net amount paid by the Plan.
* The reason(s) why the service or supply was not covered by the Plan.

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

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

Genetic Counseling - counseling by a qualified clinician that includes:

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

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

Genetic Testing- exam of blood or other tissue for changes in genes (DNA or RNA) that may indicate an increased risk for developing a specific disease or disorder, or provide information to guide the selection of treatment of certain diseases, including cancer.

Gestational Carrier **-** A Gestational Carrier is a female who becomes pregnant by having a fertilized egg (embryo) implanted in her uterus for the purpose of carrying the fetus to term for another person. The carrier does not provide the egg and is therefore not biologically (genetically) related to the child.

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 and that meets both of the following:

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

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

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

**Independent Freestanding Emergency Department –** a health care facility that**:**

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

Infertility - A disease (an interruption, cessation, or disorder of body functions, systems, or organs) of the reproductive tract which prevents the conception of a child or the ability to carry a pregnancy to delivery. It is defined by the failure to achieve a successful pregnancy after 12 months or more of appropriate, timed unprotected intercourse or Therapeutic Donor Insemination. Earlier evaluation and treatment may be justified based on medical history and physical findings and is warranted after 6 months for women age 35 years or older.

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

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

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

**Intensive Behavioral Therapy (IBT)** - outpatient Mental Health Care Services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders. The most common IBT is *Applied Behavior Analysis (ABA)*.

**Intensive Outpatient Treatment** - a structured outpatient treatment program.

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

Kidney Resource Services (KRS) - a program administered by UnitedHealthcare or its affiliates made available to you by The Maryland National Capital Park and Planning Commission. 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.
* 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.

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

Mental Health Services - services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or the Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance-Related and Addictive Disorders Administrator - the organization or individual designated by The Maryland National Capital Park and Planning Commission who provides or arranges Mental Health Services and Substance-Related and Addictive Disorders Services.

Mental Illness - those mental health or psychiatric diagnostic categories listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

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 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 a Network provider for only some products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

New Pharmaceutical Product - a Pharmaceutical Product or new dosage form of a previously approved Pharmaceutical Product. It applies to the period of time starting on the date the Pharmaceutical Product or new dosage form is approved by the U.S. Food and Drug Administration (FDA) and ends on the earlier of the following dates.

* The date as determined by the Claims Administrator or the Claims Administrator's designee, which is based on when the Pharmaceutical Product is reviewed and when utilization management strategies are implemented; or
* December 31st of the following calendar year.

 **Non-Medical 24-Hour Withdrawal Management** - An organized residential service, including those defined in *American Society of Addiction Medicine (ASAM)*, providing 24-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care.

Open Enrollment - the period of time, determined by The Maryland National Capital Park and Planning Commission, during which eligible Participants may enroll themselves and their Dependents under the Plan. The Maryland National Capital Park and Planning Commission determines the period of time that is the Open Enrollment period.

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

Participant - a full-time 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 Product(s) - *U.S. Food and Drug Administration (FDA)*-approved prescription medications, products or devices administered in connection with a Covered Health Service by a Physician.

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

Please note: Any podiatrist, dentist, psychologist, chiropractor, optometrist‍ or other provider who acts within the scope of his or her license 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 Maryland National Capital Park and Planning Commission Medical Plan.

Plan Administrator - The Maryland National Capital Park and Planning Commission or its designee.

Plan Sponsor - The Maryland National Capital Park and Planning Commission.

Pregnancy - includes all of the following:

* Prenatal care.
* Postnatal care.
* Childbirth.
* Any complications associated with the above.

Prescription Drug List (PDL) Management Committee - the committee that UnitedHealthcare designates for, among other responsibilities, classifying Pharmaceutical Products into specific tiers.

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

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

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

**Recognized Amount –**the amount which Copayment, Coinsurance and applicable deductible, is based on for the below Covered Health Services when provided by non-Network providers.

* Non-Network Emergency Health Services.
* Non-Emergency Covered Health Services received at certain Network facilities by non-Network Physicians, when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Health Service Act*. For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

The amount is based on either:

1. An *All Payer Model Agreement* if adopted,
2. State law, or
3. The lesser of the qualifying payment amount as determined under applicable law or the amount billed by the provider or facility.

The Recognized Amount for Air Ambulance services provided by a non-Network provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the Air Ambulance service provider.

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

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.

Remote Physiologic Monitoring - the automatic collection and electronic transmission of patient physiologic data that are analyzed and used by a licensed Physician or other qualified health care professional to develop and manage a plan of treatment related to a chronic and/or acute health illness or condition. The plan of treatment will provide milestones for which progress will be tracked by one or more Remote Physiologic Monitoring devices. Remote Physiologic Monitoring must be ordered by a licensed Physician or other qualified health professional who has examined the patient and with whom the patient has an established, documented, and ongoing relationship. Remote Physiologic Monitoring may not be used while the patient is inpatient at a Hospital or other facility. Use of multiple devices must be coordinated by one Physician.

**Residential Treatment** – treatment in a facility which provides Mental Health Services or Substance-Related and Addictive Disorders Services treatment. The facility meets all of the following requirements:

* It is established and operated in accordance with applicable state law for Residential Treatment programs.
* It provides a program of treatment under the active participation and direction of a Physician.
* It offers organized treatment services that feature a planned and structured regimen of care in a 24-hour setting and provides at least the following basic services;
* Room and board.
* Evaluation and diagnosis.
* Counseling.
* Referral and orientation to specialized community resources.

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

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

**Secretary** – as that term is applied in the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260)*.

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

Shared Savings Program- a program in which UnitedHealthcare may obtain a discount to a non-Network provider’s billed charges. This discount is usually based on a schedule previously agreed to by the non-Network provider and a third party vendor. When this program applies, the non-Network provider's billed charges will be discounted. Plan coinsurance and any applicable deductible would still apply to the reduced charge. Sometimes Plan provisions or administrative practices supersede the scheduled rate, and a different rate is determined by UnitedHealthcare.

This means, when contractually permitted, the Plan may pay the lesser of the Shared Savings Program discount or an amount determined by UnitedHealthcare, such as:

* A percentage of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market.
* An amount determined based on available data resources of competitive fees in that geographic area.
* A fee schedule established by a third party vendor.
* A negotiated rate with the provider.

In this case the non-Network provider may bill you for the difference between the billed amount and the rate determined by UnitedHealthcare. If this happens you should call the number on your ID Card. Shared Savings Program providers are not Network providers and are not credentialed by UnitedHealthcare.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this SPD includes Mental Illness or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorder.

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

* 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 dressing, feeding, bathing or transferring from a bed to a chair.
* They require clinical training in order to be delivered safely and effectively.
* They are not Custodial Care, which can safely and effectively be performed by trained non-medical personnel.

Skilled Nursing Facility - a Hospital or 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.

**Specialty Pharmaceutical Product -** Pharmaceutical Products that are generally high cost biotechnology drugs used to treat patients with certain illnesses.

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

Substance-Related and Addictive Disorders Services - services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Surrogate - a female who becomes pregnant usually by artificial insemination or transfer of a fertilized egg (embryo) for the purpose of carrying the fetus for another person. When the surrogate provides the egg the surrogate is biologically (genetically) related to the child.

**Telehealth/Telemedicine** - live, interactive audio with visual transmissions of a Physician-patient encounter from one site to another using telecommunications technology. The site may be a *CMS* defined originating facility or another location such as a Covered Person's home or place of work. Telehealth/Telemedicine does not include virtual care services provided by a Designated Virtual Network Provider.

Therapeutic Donor Insemination (TDI) - Insemination with a donor sperm sample for the purpose of conceiving a child.

Transitional Living - Mental Health Services and Substance-Related and Addictive Disorders Services that are provided through facilities, group homes and supervised apartments that provide 24-hour supervision, including those defined in *American Society of Addiction Medicine (ASAM)* criteria, that are either:

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

Unproven Services - health services, including medications and devices, regardless of *U.S. Food and Drug Administration (FDA)* approval, that are not determined to be effective for treatment of the medical condition or not determined to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

* Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
* Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

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 and The Maryland National Capital Park and Planning Commission may, at their discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, UnitedHealthcare and The Maryland National Capital Park and Planning Commission 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.

Urgent Care - Care that requires prompt attention to avoid adverse consequences, but does not pose an immediate threat to a person's life. Urgent care is usually delivered in a walk-in setting and without an appointment. Urgent care facilities are a location, distinct from a hospital emergency department, an office or a clinic. The purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

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

# SECTION 14 - 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 Summary Plan Description.

United Healthcare Services, Inc.
9900 Bren Road East‍
Minnetonka, MN 55343

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 Summary Plan Description, the Plan Sponsor also has selected a provider network established by ‍UnitedHealthcare Insurance Company. The named fiduciary of Plan is The Maryland National Capital Park and Planning Commission, 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.

# 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 number on 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 number on your ID card.

# ATTACHMENT II - LEGAL NOTICES

## Women's Health and Cancer Rights Act of 1998

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

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

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

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

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

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

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

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

# ATTACHMENT III – NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS

When the Plan uses the words "Claims Administrator" in this Attachment, it is a reference to United Healthcare, Inc., on behalf of itself and its affiliated companies.

The Claims Administrator on behalf of itself and its affiliated companies complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. UnitedHealthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Claims Administrator provides free aids and services to people with disabilities to communicate effectively with us, such as:

* Qualified sign language interpreters
* Written information in other formats (large print, audio, accessible electronic formats, other formats)
* Provides free language services to people whose primary language is not English, such as: Qualified interpreters
* Information written in other languages

If you need these services, please call the toll-free member number on your health plan ID card, TTY 711 or the Plan Sponsor.

If you believe that the Claims Administrator has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in writing by mail or email with the Civil Rights Coordinator identified below. A grievance must be sent within 60 calendar days of the date that you become aware of the discriminatory action and contain the name and address of the person filing it along with the problem and the requested remedy.

A written decision will be sent to you within 30 calendar days. If you disagree with the decision, you may file an appeal within 15 calendar days of receiving the decision.

|  |
| --- |
| Claims AdministratorCivil Rights Coordinator |
| United HealthCare Services, Inc. Civil Rights CoordinatorUnitedHealthcare Civil Rights GrievanceP.O. Box 30608Salt Lake City, UT 84130The toll-free member phone number listed on your health plan ID card, TTY 711 |

If you need help filing a grievance, the Civil Rights Coordinator identified above is available to help you.

You can also file a complaint directly with the U.S. Dept. of Health and Human services online, by phone or mail:

Online https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

# ATTACHMENT IV – GETTING HELP IN OTHER LANGUAGES OR FORMATS

You have the right to get help and information in your language at no cost. To request an interpreter, call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711.

This letter is also available in other formats like large print. To request the document in another format, please call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

     

# ADDENDUM - Real Appeal

This Addendum to the Plan provides Benefits for virtual obesity counseling services for eligible Covered Persons through Real Appeal. There are no deductibles, Copayments or Coinsurance you must meet or pay for when receiving these services.

## Real Appeal

The Plan provides a virtual lifestyle intervention for weight-related conditions to eligible Covered Persons 13 years of age or older. Real Appeal is designed to help those at risk from obesity-related diseases.

This intensive, multi-component behavioral intervention provides 52 weeks of support. This support includes one-on-one coaching with a live virtual coach and online group participation with supporting video content. The experience will be personalized for each individual through an introductory online session.

These Covered Health Services will be individualized and may include, but is not limited to, the following:

* Virtual support and self-help tools: Personal one-on-one coaching, group support sessions, educational videos, tailored kits, integrated web platform and mobile applications.
* Education and training materials focused on goal setting, problem-solving skills, barriers and strategies to maintain changes.
* Behavioral change counseling by a specially trained coach for clinical weight loss.

If you would like information regarding these Covered Health Services, you may contact the Claims Administrator through www.realappeal.com, https://member.realappeal.com or at the number shown on your ID card.

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