



## Maryland Health Insurance Plan

2011 Plan Year

# HMO and HealthyBlue Benefit Options Certificate of Coverage

Effective July 1, 2011 – June 30, 2012

*Administered by*

CareFirst   
BlueChoice

CareFirst   
BlueCross BlueShield

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This document describes the essential features of the Maryland Health Insurance Plan effective July 1, 2011. This document serves as the Certificate of Coverage required under §14-505(c) of the Insurance Article and COMAR 31.17.03.13.

This Certificate of Coverage is subject to the benefits and the other terms of coverage implemented by the Board of Directors of the Maryland Health Insurance Plan.

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## Your Contract with MHIP

This Certificate of Coverage (the “HMO Certificate of Coverage”) states the terms of coverage for Subscribers and Members who enroll in the Health Maintenance Organization (“HMO”) or HealthyBlue Benefit Options offered by MHIP. For Subscribers who have enrolled in the HMO Benefit Option or the HealthyBlue Benefit Option, the contract for coverage with the Plan consists of (i) this HMO Certificate of Coverage; (ii) MHIP’s Master Plan, which is filed with the Maryland Insurance Administration; (iii) the Maryland Health Insurance Plan Enrollment Application Form (“MHIP Application”) completed by the Subscriber; and, if applicable, (iv) the Medical Questionnaire, (v) the MHIP+ Application, and (vi) any Enrollment Coverage Change Form completed by the Subscriber and accepted by the Plan. These documents constitute the entire agreement between the Subscriber and MHIP. If there is a conflict between a provision of the HMO Certificate of Coverage and the Master Plan, the provision that is most beneficial to the Subscriber or other Member controls. MHIP Plan benefits are subject to change at the discretion of MHIP’s Board of Directors. This HMO Certificate of Coverage and MHIP’s Master Plan are subject to change, in writing, at the discretion of MHIP’s Board of Directors through an endorsement or amendment issued by the Plan. No other writing of any kind can modify this HMO Certificate of Coverage, the Master Plan, or the terms and conditions of coverage and benefits under the Plan. No verbal statement or other representation of any kind by any person can change, amend, revise, or otherwise modify any part of this contract, including this prohibition against any verbal amendment or modification. The availability, or unavailability, of membership in the Plan and any benefits through the Plan are at all times subject to Maryland law, and are dependent on funding by the State of Maryland.

## About This Document

This HMO Certificate of Coverage describes the Benefit Options and other features under the Plan if you have enrolled in the HMO Benefit Option or the HealthyBlue Benefit Option. **NOTE:** If you are enrolled in any other MHIP or MHIP+ Benefit Option, you must refer to a different Certificate of Coverage issued by MHIP to access the contract terms applicable to your Plan option.

This HMO Certificate of Coverage is set up in sections to help you find Plan information quickly and easily. Each section highlights different Plan features.

- **Section One** – This section provides information on Plan enrollment, coverage information, and Premiums.
- **Section Two** – This section describes how the Plan and the Benefit Options work.
- **Section Three** – This section describes what Covered Services are available under each Benefit Option and how much you pay under each Benefit Option when you receive Covered Services.
- **Section Four** – This section lists exclusions -- services that are not covered by the Plan.
- **Section Five** – This section outlines your rights and responsibilities as a Member of the Plan.
- **Section Six** – The section provides the definitions of certain terms used in this HMO Certificate of Coverage

## Some Important Terms to Know

- **Benefit Option** means Plan options authorized by the Maryland Health Insurance Plan Board of Directors that include the following options described in this Certificate of Coverage:
  - ▶ HMO Benefit Option
  - ▶ HealthyBlue Benefit Option
- **HMO Certificate** refers to this HMO Certificate of Coverage.
- **Covered Individual** refers to you and/or to any of your enrolled Dependent(s).
- **Member** refers to an individual covered under the Plan.
- **Plan or MHIP** refers to the Maryland Health Insurance Plan.
- **Plan Administrator** refers to Group Hospitalization and Medical Services, Inc. doing business as CareFirst BlueCross BlueShield (also known as “CareFirst”).
- **Plan Year** refers to the twelve consecutive months beginning July 1 and ending June 30.
- **Subscriber** refers to the primary Member whose application and eligibility are the basis for participation in the Plan and who is responsible for the payment of Premiums.
- **Type of Coverage** - One of the following Types of Coverage authorized by the Maryland Health Insurance Plan Board of Directors:
  - ▶ **Subscriber Only** – MHIP will cover you, the Subscriber, only.
  - ▶ **Subscriber and Spouse** – MHIP will cover you and your spouse.
  - ▶ **Subscriber and Child(ren)** – MHIP will cover you and one or more unmarried Dependent children under the age of 23.

- ▶ **Subscriber and Family** – MHIP will cover you, your spouse, and any unmarried Dependent children under the age of 23.
- ▶ **You or your** refers to you (an individual who qualifies for coverage under the Plan) and/or your enrolled Dependent(s).

Please refer to Section Six – Definitions, for other important terms used in this Certificate.

## Important Notice

The Maryland General Assembly established a high-risk insurance pool called the Maryland Health Insurance Plan (Chapter 153, Act of 2002, as amended from time to time) to make health insurance coverage available to medically uninsurable residents of the State of Maryland. The Plan is a State-administered health insurance program operating as an independent unit of State government. The Plan operates under the direction of the Board of Directors of the Maryland Health Insurance Plan.

MHIP has contracted with the Plan Administrator, CareFirst BlueCross BlueShield (CareFirst), to conduct many of the day-to-day operations of the Plan, including, but not limited to, processing enrollment applications, administering Prior Authorization requests and post-service claims, arranging the Health Care Provider networks, and providing other customer and administrative services for the Plan. CareFirst provides administrative services only and does not assume any financial risk or obligation with respect to health care benefit claims.

**ANY BENEFITS OR RIGHTS UNDER THE PLAN ARE NOT AN ENTITLEMENT, AND THE PLAN, THE BOARD OF DIRECTORS OF THE MARYLAND HEALTH INSURANCE PLAN, AND THE MARYLAND GENERAL ASSEMBLY HAVE CERTAIN RIGHTS UNDER THE LAW TO REVISE, CHANGE, INTERPRET OR END THE PLAN OR ANY MEDICAL BENEFITS UNDER IT, ALL OF WHICH ARE BINDING ON EACH COVERED INDIVIDUAL. MEMBERS UNDER THE PLAN WILL BE NOTIFIED OF ANY CHANGES (AMENDMENTS) TO THE PLAN AS REQUIRED BY LAW.**

### ***Information You or Your Dependent(s) Must Furnish to the Plan***

At the time you submit your application, you are required to submit to the Plan all required information that establishes the eligibility of you and your Dependent(s) for coverage under the Plan. Likewise, if you apply for the MHIP+ Premium Subsidy Program, you will be required to submit all information needed to establish your eligibility for that program. See Section One, Part B – MHIP+. Once you are covered under the Plan, you or your Dependent(s) will be required to furnish all information required in support of any claim you or your Dependent(s) submit for Covered Services under the Plan. See Section Two, Part M – Claim Processing. In addition, at the request of the Plan, you or your Dependent(s) may also be required to furnish information relating to your or their continuing eligibility for coverage under the Plan where the Plan, in its complete discretion, determines that circumstances warrant such an inquiry. If you or your Dependent(s) fail to provide the information requested by the Plan, you or your Dependent(s)' coverage under the Plan may be terminated. See Section One, Part E - When Coverage Ends.

## Section One – Enrollment and Coverage Information

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### A. When Coverage Begins and Pre-Existing Condition Limitations

Once your MHIP Application has been received, reviewed and accepted by the Plan, the Effective Date of your coverage under the Plan will be:

- If the Plan received your completed MHIP Application on or before the fifteenth (15<sup>th</sup>) day of the month, on first day of the following month. If the Plan received your completed MHIP Application after the fifteenth (15<sup>th</sup>) day of the month, on the first day of the second following month.  
For example, if the Plan received your completed MHIP Application on August 14<sup>th</sup> and you are approved for coverage your coverage would be effective on September 1<sup>st</sup>. If the Plan received your completed MHIP Application on August 20<sup>th</sup> and you are approved for coverage, your coverage would be effective on October 1<sup>st</sup>.

OR

- If your coverage eligibility is based upon your rights under the Health Insurance Portability and Accountability Act (“HIPAA”), you will have the option to choose between two possible Effective Dates (provided you apply within 63 days from when you exhausted your COBRA Coverage or group coverage): (1) the date that the Plan receives a completed MHIP Application from you, or your COBRA Coverage or group coverage expiration date, whichever is later; or (2) the Effective Date outlined above based on the Plan’s receipt of your application.

OR

- If you submitted an Enrollment Coverage Change Form during Open Enrollment requesting a change in your Benefit Option and the Plan approved your change request, the Effective Date of coverage under your new Benefit Option will be the first day of the month following Open Enrollment. **NOTE:** Benefit Option changes may only be made during Open Enrollment.

Your coverage under the Plan is subject to your initial and continued eligibility and your payment of all Plan Premiums.

#### ***Pre-Existing Condition Waiting Period***

If you are a new enrollee and you have been diagnosed with or have received or been advised to receive care or treatment for a medical condition within the six-month period immediately prior to your Effective Date, you may be subject to a six-month Pre-Existing Condition waiting period. This means that the Plan will not cover medical or Prescription Drug benefits for the treatment of the pre-existing medical condition for the first six (6) months that you are covered under the Plan. The Plan will notify you before this waiting period is imposed. This Pre-Existing Condition waiting period will not apply to the following:

- An eligible individual under HIPAA as defined in Insurance Article § 15-1301(g), Annotated Code of Maryland, provided the individual applies for the Plan coverage within sixty-three (63) days of losing prior coverage;
- A newborn child, provided that, if an additional Premium is required for the child’s coverage, the child is enrolled within thirty-one (31) days after the date of birth;
- A newly adopted child, provided that, if an additional Premium is required for the child’s coverage, the child is enrolled within thirty-one (31) days after the date of adoption; or
- An individual who has three (3) months of prior creditable coverage; is eligible for the tax credit for health insurance costs under § 35 of the Internal Revenue Code; and applies for Plan coverage within sixty-three (63) days of losing prior creditable coverage.

If an individual applies for coverage under the Plan within sixty-three days (63) of losing prior creditable coverage, the waiting period will not apply for the period of the time the individual was covered under prior creditable coverage.

A decision by MHIP to impose a six-month Pre-Existing Condition waiting period constitutes a Coverage Decision as that term is defined in Section Two, Part N (Notice of Initial Decisions and Procedures for Complaints, Grievances and Appeals) of this Certificate of Coverage and you may have a right to an Appeal under the procedures set forth in that section.

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In addition, if you are subject to a six-month pre-existing waiting period, MHIP will offer you an opportunity to purchase an endorsement to remove the Pre-Existing Condition waiting period. **You must decide whether to purchase the waiver of any Pre-Existing Condition waiting period at the time you submit your MHIP Application.** Purchasing this endorsement will require an additional Premium for twelve (12) months. If you purchase the endorsement, no Pre-Existing Condition waiting period will be imposed and the Plan will cover all health conditions under the terms of the Benefit Option you selected. **NOTE:** You may not elect to purchase an endorsement to remove the Pre-Existing Condition waiting period after you have submitted your completed MHIP Application.

### B. MHIP+

MHIP has established an optional Premium Subsidy Program called MHIP+\*\* that offers Benefit Options with reduced Premiums and expenses to MHIP Members with moderate or low household income (at or below 300% of the Federal Income Guidelines). You must be eligible for the MHIP Plan before you can apply for any Benefit Option under the MHIP+ program. MHIP Subscribers who have annual household income below certain levels may qualify for MHIP+ Benefit Options. The Benefit Options available under the MHIP+ program offer the same coverage as the standard MHIP Benefit Options for reduced Premiums. Some eligible MHIP+ Subscribers may also qualify for lower Deductibles and Plan expenses for Covered Services.

#### **Applying for MHIP+**

MHIP Members can apply for MHIP+ at any time. MHIP+ applications can be obtained by calling Member Services at (443) 725-1005 or toll free at (888) 678-1240, or by visiting the MHIP website at [www.marylandhealthinsuranceplan.state.md.us](http://www.marylandhealthinsuranceplan.state.md.us).

After you apply, MHIP will notify you if you are approved for a discounted MHIP+ Benefit Option. If your MHIP+ application is approved, and it was received by the 15th of the month, your reduced rate will become effective on the 1st of the following month. If your MHIP+ application is approved and it was received after the 15th of the month, your reduced rate will become effective the 1st of the second following month.

**NOTE:** Your Premium billing may not reflect the discount amount for one to two months after you are approved for an MHIP+ Benefit Option. Please continue to pay your standard Premium until you are notified of your new Premium amount. You will be given credit for any overpayments made after the Effective Date of the reduced rate.

#### **MHIP+ Benefit Options**

MHIP+ reduced Premium rates are available for the following benefit options offered by MHIP:

- **Health Maintenance Organization (HMO) Benefit Option-** available to all current MHIP Members with household income at or below 300% of the Federal income guidelines. (The terms of the HMO Benefit Option are contained in a separate MHIP Certificate of Coverage.)
- **\$200 Deductible Preferred Provider Organization (\$200 Deductible PPO Benefit Option)** – available to any current Member with household income at or below 200% of the Federal income guidelines.
- **\$500 Deductible Preferred Provider Organization (\$500 Deductible PPO Benefit Option)** - available to any MHIP Member with household income that is at or below 300% of the Federal income.

#### **Transition into MHIP+ Benefit Options and Deductibles**

##### *MHIP+ PPO Benefit Options*

Members of the HMO or HealthyBlue Benefit Options who qualify for MHIP+ and change their enrollment to the MHIP+ \$200 Deductible or \$500 Deductible PPO Benefit Option will be, upon the effective date of the change, subject to the same rules and receive the same benefits as Members of the standard PPO Benefit Options for a reduced Premium.

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\*\* The availability of Premium reductions and benefit enhancements under MHIP+ is based upon the availability of funds authorized by the MHIP Board. If MHIP+ enrollment and costs exceed available funding, your name will be placed on a waiting list if you qualify for MHIP+. Qualified waiting list applicants will be enrolled in the MHIP+ program based upon their application receipt date.

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- If you are currently an HMO Benefit Option Member who qualifies for and elects the \$200 PPO Benefit Option you will receive a Deductible credit based on the following schedule:
  - ▶ If your MHIP+ Effective Date is between August 1<sup>st</sup> and October 1<sup>st</sup> you will receive \$50 credited to your Deductible.
  - ▶ If your MHIP+ Effective Date is between November 1<sup>st</sup> and January 1<sup>st</sup> you will receive \$100 credited to your Deductible.
  - ▶ If your MHIP+ Effective Date is between February 1<sup>st</sup> and April 1<sup>st</sup> you will receive \$150 credited to your Deductible.
  - ▶ If your MHIP+ Effective Date is between May 1<sup>st</sup> and June 1<sup>st</sup> you will receive \$200 credited to your Deductible.
- If you are currently a Member of the HealthyBlue Benefit Option and change to the MHIP+ \$500 PPO Benefit Option, all Deductibles accumulated will be credited to the \$500 medical Deductible until met and any remaining Deductibles will be credited to the MHIP+ PPO Prescription Drug Deductible. Any remaining Deductibles after that will be forfeited.
- If you are currently a HealthyBlue Benefit Option Member and change to the MHIP+ \$200 PPO Benefit Option, all Deductibles accumulated will be credited to the \$200 medical Deductible until met and any remaining Deductible will be forfeited.

**NOTE:** All claims for Covered Services will be adjudicated based on the Benefit Option in which you were enrolled on the date of service (DOS) of the claim.

### *MHIP+ HMO Members*

MHIP+ qualified HMO Members are subject to the same rules and receive the same benefits under the HMO Benefit Option for a reduced Premium.

If you are currently a HealthyBlue Benefit Option Member and change to the MHIP+ HMO, you will receive no credit for your prior Deductible or Out-of-Pocket Maximum.

**NOTE:** All claims for Covered Services will be adjudicated based on the Benefit Option in which you were enrolled on the date of service (DOS) of the claim.

### **Annual Re-qualification for MHIP +**

In May of each year during the Open Enrollment process, Members who are enrolled in an MHIP+ Benefit Option will be required to submit an annual MHIP+ Re-Certification Application and a copy of your federal income tax return for the prior year in order to re-qualify for the MHIP+ program. If you no longer qualify for MHIP+ for any reason, you will be assigned to a comparable standard MHIP Benefit Option at the standard Premium rate.

## C. Your Premium

### **Calculation of Your Premium**

The Board of Directors of the Maryland Health Insurance Plan establishes the monthly Premiums for each Benefit Option and for each MHIP+ Benefit Option for the Plan Year. Plan Premiums may be increased or decreased during the Plan Year at the discretion of the Board of Directors.

The monthly Premium that you will pay during the Plan Year is determined by the following:

- The Benefit Option you select;
- The Type of Coverage you select;
- The age of the **oldest** Covered Individual under the Type of Coverage you have selected; and
- Whether you have purchased an endorsement to remove a Pre-Existing Condition waiting period.

### **Payment of Your Premium**

Your Premium payment is due by the first of each month of coverage.

- For those Members eligible for the tax credit for health insurance costs under §35 of the Internal Revenue Code (HCTC) and who elect to have their tax credit advanced to the Plan from the federal government, the Premium payments due from you are also due by the first of each month

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For all Members, the Plan will notify you of your monthly Premium amount. MHIP Subscribers will receive Premium invoices on a monthly basis.

Premium payments are payable by personal check or automatic debit. Checks should be made payable to **MHIP**. MHIP does not accept credit card or phone payments. Should you submit a payment without your Premium statement, you must include both the Subscriber's name and the MHIP membership number from the Subscriber's MHIP ID card on your check.

Premium payments must be mailed to:

CareFirst TPA for State of Maryland  
PO Box 791134  
Baltimore, MD 21279-1134

### **Automatic Debit Plan**

The Plan Administrator offers you the ability to pay your Premium using automatic payment from a checking account. You may enroll in the automatic payment plan, if available, by completing an Automatic Debit Plan Authorization Form available on the MHIP website ([www.marylandhealthinsuranceplan.state.md.us](http://www.marylandhealthinsuranceplan.state.md.us)). You may be subject to a charge from the Plan, as well as from your financial institution for any Premium payment, made by check or automatic withdrawal from a checking account that is returned for insufficient funds.

**NOTE:** Members eligible for the tax credit for health insurance costs under §35 of the Internal Revenue Code and who elect to have their tax credit advanced to the Plan from the federal government are not eligible to enroll in an automatic payment plan.

### **Grace Period**

The Grace Period is 60 calendar days following the due date of your Premium.

If you pay your Premium during the Grace Period, your coverage will continue under the Plan. However, if your full Premium payment is not received by the 60<sup>th</sup> day following the Premium due date, your coverage shall be terminated on the last day of the Grace Period without further advance notice. (See Section One, Part E – When Coverage Ends.) The Plan Administrator will send a letter to you if your payment is not made after it is due.

For example, if your Premium is due September 1<sup>st</sup> and the Plan does not receive your Premium payment by October 31<sup>st</sup>, then your coverage will be terminated on October 31<sup>st</sup> at midnight. If your coverage is terminated for failure to pay your Premium during the Grace Period, you will have to wait one year before you can reapply to the Plan.

### **Premium Adjustments**

During the Plan Year, your Premium may increase because:

- The Board of Directors of the Maryland Health Insurance Plan, at its discretion, increased Premium rates as required by Maryland law to keep pace with increased costs in the individual insurance market in Maryland or to maintain the solvency of the Plan.
- The age of the **oldest** Covered Individual under your MHIP contract moved from one of the following age bands to another:
  - Under age 30;
  - Ages 30 through 34;
  - Ages 35 through 39;
  - Ages 40 through 44;
  - Ages 45 through 49;
  - Ages 50 through 54;
  - Ages 55 through 59;
  - Ages 60 through 64; and
  - Ages 65 and Over.
- You experience a qualifying event that results in the addition or removal of Covered Individuals to your contract, thereby causing a change in your Type of Coverage. (See Section One, Part D – Coverage Changes).

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Any Premium change will take effect the first of the month after any Premium increase, age band change or Type of Coverage change has taken effect. The Plan will calculate the new Premium based upon the age of the **oldest** Covered Individual on your MHIP contract as of the Effective Date of the change.

### D. Coverage Changes

#### ***Changing Your Coverage Due to a Qualifying Status Change***

Once you become enrolled in the Plan, the Type of Coverage that you select for you and any eligible and enrolled Dependents remains in effect until the next Plan Year begins. See Section Two – How the Plan Works and Section Six – Definitions – for a description of the Dependents who are eligible to enroll with you. The Types of Coverage available under the Plan are:

- **Subscriber Only**
- **Subscriber and Spouse**
- **Subscriber and Child(ren)**
- **Subscriber and Family**

You are only allowed to select or change a Type of Coverage under the Plan either (i) at the time of your initial enrollment in the Plan; (ii) during the Plan's annual Open Enrollment period or (iii) if you experience a qualifying event such as a change in your marital status or the number of your eligible Dependents.

To change your Type of Coverage during the Plan Year due to a qualifying event, you must complete an Enrollment Coverage Change Form and submit it to the Plan Administrator within the timeframes outlined below:

#### ***Qualifying Events***

***Change of Marital Status*** – Your legal marital status changes because of marriage, divorce, annulment or death of a spouse. In the event of divorce you are required to notify the Plan and drop your former spouse from coverage under the Plan. If you experience a change of marital status and you want to add or remove your spouse, you must do the following:

- Complete an Enrollment Coverage Change Form either adding or removing your spouse. You may not request Benefit Option changes at this time.
- Mail the form, along with any supporting documentation (i.e. a marriage license or divorce decree), to the Plan Administrator within the first thirty-one (31) days following the date of the qualifying event.
- You will receive an acknowledgement in writing of the change you have requested as well as new Premium payment invoices reflecting the change to your Type of Coverage under the Plan.

If you do not submit an Enrollment Coverage Change Form to the Plan Administrator to add a spouse within the first thirty-one (31) days following the date of the qualifying event, you will only be able to add your spouse during the Plan's next Open Enrollment period.

If you are removing a spouse from coverage under the Plan, your spouse's coverage will terminate on the last day of the month in which the Plan Administrator received the Enrollment Coverage Change Form. In the event of a divorce, your former spouse may obtain separate coverage under the Plan without re-qualifying if he or she makes the request for separate coverage in writing within the first thirty-one (31) days following the qualifying event.

***Dependent Children (Birth or Adoption)*** – Your number of unmarried Dependent children changes for reasons such as birth, adoption (or placement for adoption) or marriage. Children who are born or adopted are automatically covered under your Benefit Option for the first thirty-one (31) days following the event. If you add your qualifying Dependent and that addition results in a change of coverage type, you will be required to pay any increases in Premium from the date of the qualifying event.

For example, if you have a Subscriber and Spouse coverage and you have a new baby on January 3, 2012, your newborn will be automatically be covered for the first thirty-one (31) days of life, until February 2, 2012. If you add your child to your coverage under the Plan, your Type of Coverage will change from *Subscriber and Spouse* to *Subscriber and Family*, effective January 3, 2012. You will be required to pay the increase in Premium from January 3, 2012, in order for your change to take effect.

If you want to change your coverage by adding an eligible Dependent child or children, you must do the following:

- Complete an Enrollment Coverage Change Form adding the Dependent(s) to your current coverage. You

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- may not request Benefit Option changes at this time.
- Mail the form, along with any supporting documentation (i.e. adoption decree or official birth record), to the Plan Administrator. If an additional Premium is required for the child's coverage, the form and supporting documentation must be mailed within the first thirty-one (31) days following the date of the birth or adoption.
- You will receive an acknowledgement in writing of the change you have requested. If the change results in a change in your Type of Coverage, you will also receive new Premium payment invoices reflecting that change.

Except for the addition of a newborn or newly adopted child for whom no additional Premium is required, if you do not submit an Enrollment Coverage Change Form to the Plan Administrator to add a Dependent within the first thirty-one (31) days following the date of the qualifying event, you will only be able to add your Dependent during the Plan's next Open Enrollment period.

*Spouse's or Dependent's Loss of Other Coverage* – A spouse or other Dependent may have lost other coverage under certain circumstances:

- A change in your spouse's or other Dependent's employment status that affects his/her eligibility under a previous health plan in which he/she was enrolled at the time of your enrollment in the Plan or in which he/she was enrolled at the time of the most recent prior MHIP Open Enrollment period, whichever is later.
- A Dependent no longer meets eligibility criteria or has become ineligible for other coverage that he/she had at the time of your enrollment or that he/she had during the most recent prior MHIP Open Enrollment period, whichever is later.
- A change in the public assistance status of a spouse or other Dependent who was receiving benefits under Medicare, Medicaid or the Maryland Children's Health Program, if he or she was receiving assistance under these programs at the time of your enrollment or during the most recent prior MHIP Open Enrollment period, whichever is later.

**NOTE:** A spouse's or other Dependent's voluntary termination of other health insurance coverage is not a qualifying event, unless it is the result of their termination from employment.

If you want to add Dependent(s) under these circumstances, you must do the following:

- Complete an Enrollment Coverage Change Form adding the Dependent(s) to your current coverage under the Plan. You may not make Benefit Option changes at this time.
- Mail the form, along with any supporting documentation, to the Plan Administrator within thirty-one (31) days after the qualifying event.
- You will receive an acknowledgement in writing of the change you have requested as well as new Premium payment invoices reflecting the change.

If you do not submit an Enrollment Coverage Change Form to the Plan Administrator within the first thirty-one (31) days following a spouse's or other Dependent's loss of other coverage, you will only be able to add the Dependent(s) during the Plan's next Open Enrollment period.

*Loss of Eligibility for Payment of Premiums by Governmental Unit* – If you are enrolled in a program under which a governmental unit pays your premiums for MHIP coverage and you lose your eligibility for that program, you may elect to change to another benefit option. To change to another benefit option, you must:

- Complete an Enrollment Coverage Change Form indicating the change in benefit options;
- Mail the completed form to the Plan Administrator within the first 31 days after the loss of eligibility for the program; and
- Include with the form a notice from the governmental unit indicating that you are no longer eligible for the program under which the governmental unit paid your MHIP premiums.

You will receive acknowledgement in writing of the change you have requested as well as new premium invoices that reflect the change in benefit options.

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*Enrollment Change Forms* – You can obtain an Enrollment Coverage Change Form on the MHIP website at [www.marylandhealthinsuranceplan.state.md.us](http://www.marylandhealthinsuranceplan.state.md.us) or by calling Member Services at (443) 725-1010 or toll free at (888) 456-2024.

Enrollment Coverage Change Forms should be mailed to:

Maryland Health Insurance Plan  
10455 Mill Run Circle RR-291  
Owings Mills, MD 21117

### ***Adding an MHIP- Eligible Dependent Who Was Not Initially Covered on Your Effective Date of Coverage.***

You may change the Type of Coverage you selected during the Plan Year by adding a Dependent who was not covered on your Effective Date, but would otherwise qualify as eligible for MHIP on his or her own, to your coverage under the Plan. In order to add such an eligible Dependent, the Dependent must complete a separate individual MHIP application documenting his or her independent eligibility for the Plan. A Dependent who does not qualify as eligible for MHIP on his or her own cannot be added to your coverage under the Plan in this way.

### ***Qualified Medical Child Support Order (QMCSO)***

In accordance with federal law, the Plan will provide medical coverage to certain Dependent children (called “Alternate Recipients”) if the Plan is directed to do so by a Qualified Medical Child Support Order (QMCSO). Generally, QMCSO is an order or judgment from a court or produced as a result of a state-authorized administrative process directing the Plan to include a child in the Member’s coverage. A QMCSO is qualified and enforceable if it specifies:

- Your name and last known address,
- Each Alternate Recipient’s name and address,
- A reasonable description of the coverage to which the Alternate Recipient is entitled,
- The Effective Date of coverage,
- How long the child is entitled to coverage, and
- Each health plan subject to the order.

When the Plan receives a QMCSO, the Plan will promptly notify you that the order has been received, as well as what procedures the Plan will use to determine if the order is qualified.

The Plan will then decide, based on the Plan’s written procedures and within a reasonable time, whether the order is qualified. Once the decision is made, the Plan will notify the Member and Alternate Recipient by mail.

### ***Benefit Option Changes***

You cannot change your Benefit Option during the Plan Year. Once you become enrolled in the Plan, the Benefit Option that you select will remain in effect until the next Plan Year begins. You can only make a change in your Benefit Option by submitting an Enrollment Coverage Change Form during the Plan’s annual Open Enrollment period.

**EXCEPTION:** If you qualify for the MHIP+ Premium Subsidy Program after you enroll in the Plan, you may change your Benefit Option to a MHIP+ Benefit Option that you qualify for and select. For more information about the MHIP+ program, see Section One, Part B.

### ***Updating Your Address***

The Plan Administrator maintains addresses for each Member: a physical address and a mailing address. Your physical address is used to determine Maryland residency. Your mailing address is where all Plan correspondence, including enrollment or Plan informational materials, ID cards, Premium notices, and Appeal Decision letters, will be sent. These addresses may be the same.

Any changes to your physical address or mailing address must be made in writing. Notations on Premium notices or other Plan materials will not be considered an official notification of an address change. To make a change to your physical address or mailing address, you must send a letter requesting the address change to:

Maryland Health Insurance Plan  
10455 Mill Run Circle RR-291  
Owings Mills, MD 21117

## Section One – Enrollment and Coverage Information

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### E. When Coverage Ends

#### ***Voluntary Termination of Coverage***

You may cancel MHIP coverage for yourself or for a Dependent at any time. To cancel MHIP coverage, a letter must be sent requesting the cancellation to:

Maryland Health Insurance Plan  
10455 Mill Run Circle RR-291  
Owings Mills, MD 21117

Coverage will be terminated on the last day of the month in which the Plan receives your written request. However, if you have not paid the Premium due for that month, coverage will terminate at the end of that month for nonpayment of Premium in lieu of a voluntary termination. If you have voluntarily terminated coverage under the Plan, any Premium balance remaining on your account after the date of termination of coverage will be refunded to you.

#### ***Termination of Coverage for Nonpayment of Premium***

Your coverage under the Plan will automatically terminate at the end of the Grace Period if you have not paid the required Premium.

The Grace Period is the sixty (60) calendar days after the date your Premium is due.

For example, if your Premium is due September 1<sup>st</sup> and the Plan does not receive your Premium payment by October 31<sup>st</sup>, then your coverage will be terminated on October 31<sup>st</sup> at midnight.

The Plan Administrator will provide a warning of termination to you if your payment is not received after the Premium due date. If you pay your Premium during the Grace Period, your coverage will continue under the Plan.

#### ***Termination of Coverage for Fraud or Misrepresentation***

You and your Dependent(s)' coverage under the Plan will end if:

- You or your Dependent(s) perform an act or practice that constitutes fraud; or
- You or your Dependent(s) made an intentional misrepresentation of material fact in your MHIP Application or, if applicable, your Medical Questionnaire.

When information becomes available to the Plan Administrator that one of the above circumstances may exist, you may be required to provide documentation to the Plan. If a Subscriber's coverage terminates for these reasons, coverage for the Subscriber and any of the Subscriber's Dependents will end following notice from the Plan Administrator on the following dates:

- If the Plan Administrator gives notice of termination prior to the fifteenth (15<sup>th</sup>) day of a month, coverage shall terminate at the end of that month; or
- If the Plan Administrator gives notice of termination on or after the fifteenth (15<sup>th</sup>) day of the month, coverage shall terminate at the end of the following month.

#### ***Termination of Coverage for Non-Eligibility (Eligible for Substantially Similar Coverage)***

Your coverage under the Plan will end when you no longer qualify as a Medically Uninsurable Individual under the following circumstances:

- You become covered under other coverage that is substantially similar to MHIP coverage;
- You become eligible for coverage under Medicare, the Maryland Medical Assistance Program (Medicaid) or the Maryland Children's Health Program (MCHP); or
- You become eligible for employer-sponsored coverage that includes benefits comparable to MHIP benefits. This does not apply if you are eligible for employer-sponsored group health insurance, but you are unable to activate such coverage during a mandatory initial waiting period. An exception to this provision also exists if you are eligible for the tax credit for health insurance costs under §35 of the Internal Revenue Code and your employer pays for less than 50% of the cost of the coverage.

When information becomes available to the Plan Administrator that one of the above circumstances may exist, you

## Section One – Enrollment and Coverage Information

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may be required to provide documentation to the Plan.

If your coverage terminates for non-eligibility based on reasons other than because you have become eligible for Medicare, coverage for the Member and any of the Member's Dependents will end following notice from the Plan Administrator as follows:

- If you receive a termination notice from the Plan dated before the fifteenth (15<sup>th</sup>) day of the month, your termination date is the last day of the month in which the notice was sent.
- If you receive a termination notice from the Plan dated on or after the fifteenth (15<sup>th</sup>) day of the month, your termination date is the last day of the month following the month in which the notice was sent.  
For example, if the Plan notifies you of termination on August 14<sup>th</sup>, your coverage will terminate at midnight on August 31<sup>st</sup>. If the Plan notifies you of termination on August 16<sup>th</sup>, your coverage will terminate at midnight on September 30<sup>th</sup>.

If your coverage is terminating because you have become eligible for Medicare, the Plan will give you ninety (90) days notice before terminating your coverage. **NOTE:** If you notify the Plan or the Plan otherwise learns that you are receiving Medicare, no ninety (90) day notice will be given and your termination date will be determined in the same manner as outlined above for all other terminations for non-eligibility.

You may appeal the Plan's decision to terminate your coverage for non-eligibility. Procedures for filing an Appeal are outlined in Section Two, Part N – Notice of Initial Decisions and Procedures for Complaints, Grievances or Appeals.

If your coverage under the Plan is terminated for non-eligibility, your Dependent(s) may retain MHIP coverage if they are not eligible for coverage under your new health coverage. In order for your Dependent(s) to retain MHIP coverage, you must send a letter requesting continuation of coverage for your Dependent(s) to:

Maryland Health Insurance Plan  
10455 Mill Run Circle RR-291  
Owings Mills, MD 21117

Your Dependent(s)' coverage will be converted to a new contract the first day of the month after your coverage is terminated. The new Type of Coverage will be as follows:

- If only your spouse remains covered under the Plan, your spouse's new Type of Coverage will be *Subscriber Only*.
- If your spouse and children remain covered under the Plan, their new Type of Coverage will be *Subscriber and Child(ren)*. If only your minor Dependent children remain covered under the Plan, the new Type of Coverage will be a *Subscriber Only*. If more than one child remains covered under the Plan, MHIP will give each child a separate *Subscriber Only* contract.

**NOTE:** You are required to notify the Plan if you or your Dependents have or become eligible for other coverage, including, but not limited to, employer sponsored group coverage, Medicare, Medicaid or MCHP. You are responsible for all Premiums for you and your Dependents' coverage while enrolled in the Plan, whether or not you or your Dependents were eligible, except if you have requested termination of coverage in writing. When you request termination of coverage in writing, your coverage under the Plan will terminate at the end of the month in which your request was received.

### ***Termination of Coverage for Non-Eligibility (Residency or Dependent Age)***

Coverage for you and/or your Dependent(s) will terminate at midnight on the last day of the month when:

- You no longer reside in the State of Maryland. The Plan reserves the right to ask any Member to complete a residency questionnaire at any time. On a regular basis, the Plan Administrator will review your physical address. Any Member with a physical address outside the State of Maryland may be asked to complete a residency questionnaire and provide documentation of Maryland residency.
- A Dependent child reaches age 23, unless the Dependent is unable to support him or herself due to physical or mental incapacity which existed or occurred while MHIP coverage was in effect.

If your coverage terminates for non-eligibility based on your residency or the age of your Dependent, coverage will

## Section One – Enrollment and Coverage Information

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end for you or your Dependent following notice from the Plan Administrator as follows:

- If you receive a termination notice from the Plan dated before the fifteenth (15<sup>th</sup>) day of the month, your termination date is the last day of the month in which the notice was sent.
- If you receive a termination notice from the Plan dated on or after the fifteenth (15<sup>th</sup>) day of the month, your termination date is the last day of the month following the month in which the notice was sent. For example, if the Plan notifies you of termination on August 14<sup>th</sup>, your coverage will terminate at midnight on August 31<sup>st</sup>. If the Plan notifies you of termination on August 16<sup>th</sup>, your coverage will terminate at midnight on September 30<sup>th</sup>.

You may appeal the Plan's decision to terminate you or your Dependent's coverage for non-eligibility. Procedures for filing an Appeal are outlined in Section Two, Part M – Notice of Initial Decisions and Procedures for Complaints, Grievances or Appeals.

### ***Extension of Coverage***

Coverage may be extended to you beyond your termination date in the following circumstances:

- In the event that you are receiving Inpatient Hospital services and your admission was authorized by the Plan prior to your termination of coverage, your admission will continue to be covered by the Plan until you are discharged from the Inpatient facility or the date the Plan Administrator determines that Inpatient care is no longer Medically Necessary (whichever occurs first).
- In the event that you have a claim in progress, your care related to the claim in progress will continue to be covered by the Plan until the earlier of (i) the date you are released from the care of a Health Care Provider for the condition that is the basis of the claim or the date the Plan Administrator determines that care is no longer Medically Necessary (whichever occurs first); or (ii) twelve (12) months after the date your coverage terminates.

### ***Reinstatement***

The Plan will reinstate your coverage if you appeal the termination decision, show that your termination from the Plan was the result of a Plan error, and pay any outstanding premium. If you are reinstated, the plan will pay for covered services incurred since your termination date, consistent with all the terms, conditions, limitations, and exclusions of the plan. The Plan will not reinstate your coverage under the following circumstances:

- If your coverage under the Plan has been terminated due to fraud or intentional misrepresentation, or;
- If your coverage under the Plan was terminated for nonpayment of Premium

### ***New Applications for Coverage***

If your coverage under the Plan terminates for any reason and you are not reinstated through MHIP's formal Appeal process, you must re-apply and re-qualify in order to receive new coverage under the Plan. Your application for coverage will be denied if:

- If your coverage under the Plan has been terminated due to fraud or intentional misrepresentation, or;
- If your coverage under the Plan was terminated for nonpayment of Premium and you apply for coverage under the Plan within twelve (12) months of your termination date. However, your coverage may be reinstated if you:
  - ▶ Became covered under other Substantially Similar Coverage within sixty-three (63) days of the termination of your coverage under the Plan; and
  - ▶ Were terminated from the Substantially Similar Coverage for a reason other than nonpayment of Premium; and
  - ▶ Apply for Plan coverage within sixty-three (63) days of being terminated from the Substantially Similar Coverage.

## **F. Health Insurance Portability and Accountability Act (HIPAA)**

Federal legislation, known as HIPAA (the Health Insurance Portability and Accountability Act of 1996), establishes certain federal standards for the portability of health insurance coverage and the uses and disclosures of your personal health information.

## Section One – Enrollment and Coverage Information

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### ***Your Right to a Certificate of Creditable Health Coverage***

You have the right to receive a certificate of creditable health coverage from the Plan. The Plan Administrator will automatically issue a certificate of creditable coverage to you when your coverage under the Plan ends.

You may also request a copy of your certificate of creditable health coverage at any time for purposes of documenting current MHIP coverage or within the first twenty-four (24) months after your coverage terminates.

You may request a certificate of creditable health coverage by calling Member Services at (443) 725-1010 or toll free at (888) 456-2024, or by sending a written request to:

Maryland Health Insurance Plan  
10455 Mill Run Circle RR-291  
Owings Mills, MD 21117

The certificate of creditable health coverage contains all the necessary information another health plan will need to determine if you had prior continuous coverage that should be credited toward any Pre-Existing Condition limitation period.

### ***Disclosure of Confidential Health Information***

This section contains information on the use of health information for administration and funding of the Plan, as well as the rights you are entitled to as a Member of the Plan.

HIPAA places restrictions on when someone other than you may have access to your health information. The Plan may use or disclose your health information for Plan administration functions—those activities the Plan and its Plan Administrator perform to administer MHIP.

These activities include but are not limited to:

- Determining eligibility under the Plan;
- Processing Prior Authorization or claims payment requests;
- Coordinating benefits with other coverage;
- Performing customer service; and
- Processing a Grievance or Appeal.

The Plan Administrator agrees not to use or disclose your health information for purposes other than Plan administration functions, as required by law, or as authorized by you. The Plan Administrator will report to the Board of Directors of the Maryland Health Insurance Plan if it makes any use or disclosure that is inconsistent with these restrictions. If the Plan Administrator gives your health information to any agents or subcontractors of the Plan Administrator that support or provide Plan administrative functions, those agents or subcontractors also will agree to these same restrictions.

The Plan Administrator also agrees to return or destroy all of your health information when it no longer needs your information to perform Plan administration functions. If this return or destruction is not feasible (such as where the Plan Administrator is required to retain your health information for its legal obligations), the Plan Administrator will limit further uses or disclosures of your health information to those purposes that make the return or destruction infeasible.

You also have certain rights with regard to your health information held by the Plan Administrator to perform Plan administration functions. First, the Plan Administrator will make the health information it holds about you available to you for inspection and copying. Second, if you believe that your health information held by the Plan Administrator is erroneous or incomplete, you have the right to request the Plan Administrator to amend that information. Third, if the Plan Administrator makes certain disclosures of your health information for purposes other than Plan administration, the Plan Administrator will give you a list of those disclosures.

You have the right to have the Plan disclose information to a third party by completing a Privacy Authorization Form. The Plan will limit the disclosure of such information to such third party as specified on the Privacy Authorization Form.

## Section Two – How The Plan Works

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### A. Types of Coverage

The Plan offers four Types of Coverage. The coverage you select will determine who is covered under your contract. You can only make a Type of Coverage selection (i) at the time of your initial enrollment, (ii) during Open Enrollment or (iii) upon the occurrence of a qualifying event such as a change in your marital status or in the number of your eligible Dependents (see Section One, Part D – Coverage Changes).

- **Subscriber Only** – MHIP will cover you, the Subscriber, only.
- **Subscriber and Spouse** – MHIP will cover you and your spouse.
- **Subscriber and Child(ren)** – MHIP will cover you and one or more unmarried Dependent children.
- **Subscriber and Family** – MHIP will cover you, your spouse, and any unmarried Dependent children.

Once you qualify for coverage under the Plan you may enroll yourself, as a Subscriber, and enroll any eligible Dependents. A Dependent includes:

- A lawful spouse;
- An unmarried child who is less than age 23 and is a biological child, stepchild, or foster child;
- A lawfully adopted unmarried child (or child in the process of being adopted) who is less than age 23, as of the date of placement for adoption;
- An unmarried child who is less than age 23 for whom you have been granted legal custody, including custody as a result of guardianship, other than a temporary guardianship of less than 12 months duration, granted by a court or testamentary appointment;
- An unmarried child who is less than age 23 for whom you have the legal obligation to provide coverage pursuant to court order, court-approved agreement, or testamentary appointment; and
- An unmarried child who is over the age of 23 but is incapable of self-support because of mental or physical incapacity that began before the child attained the age of 23 and who resides at the home of the Subscriber and relies on the Subscriber for material support.

### B. The HMO and HealthyBlue Benefit Options

The Plan offers two HMO-based Benefit Options to choose from at the time you enroll or during the annual Plan Open Enrollment period. These HMO-based Benefit Options are:

- **HMO Benefit Option**
- **HealthyBlue Benefit Option**

All Members on the same contract must have the same Benefit Option.

#### ***The HMO Benefit Option***

The HMO Benefit Option requires each Member to use providers that participate in the CareFirst BlueChoice Provider network and to obtain a Referral from the Primary Care Provider when a Member seeks care from a Specialist or other Health Care Provider. HMO Benefit Option Members do not have the option to use Specialists and other Providers outside of the CareFirst BlueChoice Provider network.

#### ***Selecting a Primary Care Provider***

MHIP requires each Member joining the HMO Benefit Option to establish and maintain a relationship with a Primary Care Provider (“PCP”). A Primary Care Provider is a Contracting Physician or Contracting Provider who is part of the CareFirst BlueChoice Provider network and who is selected by a Member to provide and manage the Member’s health care.

A Primary Care Provider can be any of the following types of Health Care Providers: Family Practice, General Practice, Internal Medicine, Obstetrics/Gynecology and/or Pediatrics. Your Primary Care Provider will coordinate all of your Health Care Services, except in the case of an emergency.

A Member must select his or her Primary Care Provider from the current list of Contracting Providers in the CareFirst BlueChoice Provider network. If a specific Primary Care Provider is not available, the Plan Administrator will assist the Member in making another selection.

**NOTE:** Unless otherwise provided in this HMO Certificate of Coverage, the HMO Benefit Option does not cover MHIP/HMO-HB/COC (7/11)

## Section Two – How The Plan Works

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Health Care Services that are rendered by Health Care Providers outside of the CareFirst BlueChoice Provider network (also known as “Non-Contracting Providers”). This restriction does not apply to (i) Emergency Services, (ii) urgent care or (iii) Medically Necessary follow-up care -- coordinated by your Primary Care Provider -- that is related to emergency surgical services rendered by a Health Care Provider in emergency situations.

### **Changing Your Primary Care Provider**

If you have enrolled in the HMO Benefit Option, you must select a contracting Primary Care Provider. You will have the option to change your Primary Care Provider once a month during the Plan Year. You must contact Member Services at (443) 725-1010 or toll free at (888) 456-2024 to request the change. Requests for Primary Care Provider changes that are made prior to the fifteenth (15<sup>th</sup>) of the month will be effective on the first (1<sup>st</sup>) of the next month. Requests that are received on or after the fifteenth (15<sup>th</sup>) of the month will be effective on the first (1<sup>st</sup>) of the month that follows the next month.

### **Referrals to Other Contracting Providers**

When you are in need of specialty care, you must obtain a Referral from your Primary Care Provider to see another Contracting Provider who is part of the CareFirst BlueChoice Provider network. In certain limited cases, you may self-refer yourself to a Specialist. In other circumstances, you can obtain a Standing Referral or a Condition Management Referral.

### **Self-Referrals**

You may obtain services directly from another Contracting Provider who is a part of the CareFirst BlueChoice Provider network without a Referral from your Primary Care Provider for the following Covered Services:

- Covered gynecological and obstetric services from a Contracting Provider certified nurse midwife or Contracting Provider Obstetrician/Gynecologist, **except** for infertility testing and diagnostic services;
- Covered Services rendered at a Contracting Provider’s radiologist offices whether ordered by a Contracting Provider or a Non-Contracting Provider;
- Covered Services rendered by a Contracting Provider laboratory whether ordered by a Contracting Provider or a Non-Contracting Provider;
- Covered Services rendered by a Contracting Provider ophthalmologist for diagnosis and treatment for medical conditions of the eye.
- Covered Services rendered by a Contracting Limited Service Immediate Care Center.
- Outpatient Mental Health and Substance Abuse Services. Prior Authorization must be obtained from the Mental Health Management Program. The contact information for the Mental Health Management Program is located on the Member’s identification card.
- Emergency Services and urgent care; and
- Covered Services that are directly related to a diagnosis of cancer, including, but not limited to, office visits and care by an oncologist, chemotherapy, and radiation therapy by Contracting Providers do not need a Referral by the Member’s Primary Care Provider.

### **Standing or Condition Management Referral by your Primary Care Provider to a Specialist**

Under other circumstances, you may also obtain a Standing Referral or Condition Management Referral from your PCP to a Specialist:

- A Member may request a Condition Management Referral or a Standing Referral from the Primary Care Provider to a Specialist for a condition that:
  - ▶ Is life threatening, degenerative, chronic or disabling; or
  - ▶ Requires a Specialist over a prolonged period of time.
  - ▶ **NOTE:** Upon request for a Condition Management Referral, the Primary Care Provider will contact the Plan Administrator to obtain Prior Authorization.
- A Member who has been diagnosed with cancer may request a Standing Referral from their Primary Care Provider to a:
  - ▶ Contracting Physician who is a board-certified physician in pain management; or
  - ▶ Contracting Physician who is an oncologist.
  - ▶ **NOTE:** A Standing Referral does not authorize the Contracting Physician to assume the responsibilities for care other than cancer care and pain management. The Referral is subject to periodic review by the Primary Care Provider and the Plan Administrator.
- Standing Referral for Pregnancy.
  - ▶ A Member who is pregnant may obtain a Standing Referral to an obstetrician.

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- ▶ **NOTE:** After the Member who is pregnant receives a Standing Referral to an obstetrician, the obstetrician is responsible for the primary management of the Member's pregnancy, including the issuance of referrals in accordance with the Plan Administrator's policies and procedures, through the postpartum period.

### **Conditions for a Referral to a Specialist or Non-Physician Specialist who is not a Contracting Provider.**

A Referral to a Specialist or a Non-Physician Specialist who is not an In-Network Provider shall be provided if the Member is diagnosed with a condition or disease that requires specialized health care services or medical care; and

- CareFirst BlueChoice does not contract with a Specialist or Non-Physician Specialist with the professional training and expertise to treat or provide health care services for the condition or disease; or
- CareFirst BlueChoice cannot provide reasonable access to a Specialist or Non-Physician Specialist with the professional training and expertise to treat or provide health care services for the condition or disease without unreasonable delay or travel.

For purposes of calculating any Deductible, Copayment amount, or Coinsurance payable by the Member, CareFirst BlueChoice will treat the services received by the Specialist or Non-Physician Specialist as if the service was provided by a Contracting Physician or Contracting Provider.

A decision by CareFirst BlueChoice not to provide access to or coverage of treatment or health care services by a Specialist or Non-Physician Specialist in accordance with this provision constitutes an Adverse Decision as defined in this HMO Certificate of Coverage if the decision is based on a finding that the proposed service is not Medically Necessary, appropriate, or efficient. See Section Two, Part N - Notice of Initial Decisions and Procedures for Complaints, Grievances and Appeals.

### **The HealthyBlue Benefit Option**

The HealthyBlue Benefit Option offers three (3) levels of benefits. The Member may select the benefit level at which coverage will be provided each time care is sought. Under the HealthyBlue Benefit Option, the Member may receive benefits for a particular service under the Option 1 component, the Option 2 component or the Option 3 component. The Member may not receive duplicate benefits for the same Covered Services.

- Option 1: Except as otherwise provided in this Section, benefits will be considered Option 1 when the Member obtains Covered Services from his or her Primary Care Provider or from a Specialist or other Health Care Provider who participates in the CareFirst BlueChoice Provider network pursuant to a Referral from the Member's Primary Care Provider.
- Option 2: Benefits will be considered Option 2 when the Member obtains Covered Services from any Health Care Provider who participates in the CareFirst BlueChoice Provider network without obtaining a Referral from their Primary Care Provider (the open access feature).
- Option 3: Benefits will be considered Option 3 when the Member obtains Covered Services from an Out-of-Network Provider who does not participate in the CareFirst BlueChoice Provider network. An Out-of-Network Provider may be a Participating Provider or Non-Participating Provider.

#### **Option 1**

When Option 1 benefits apply, the Member is eligible for a higher level of benefits than the Option 2 and Option 3 benefits. For Option 1 benefits to apply:

- The Member must be assigned to a Primary Care Provider at enrollment, and,
- Except where otherwise stated in this Certificate, that Primary Care Provider must manage the Member's care by providing Referrals to Specialists.

If the Member is unable to see their Primary Care Provider, the Member may obtain Covered Services from any In-Network Provider Primary Care Provider. If the Member requires care from a Specialist, a Referral must be obtained from the Member's Primary Care Provider, except in the instances described in the Referral Requirements provision below.

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Covered Services rendered by an In-Network Mental Health and Substance Abuse Services Provider, including inpatient facility services, inpatient professional services, medication management services, methadone maintenance services, residential crisis facility services, residential crisis professional services and partial hospitalization services, will be covered under Option 1.

### *Referral Requirements.*

Option 1 benefits for services rendered by Specialists and other Health Care Providers other than the Primary Care Provider who participate in the CareFirst BlueChoice Provider network (In-Network Providers) are available only when:

- Prior Referral by the Primary Care Provider is obtained for the specified Covered Service; or
- Prior Referral by the Primary Care Provider is obtained for Covered Services rendered or ordered by an In-Network Provider.

After the initial Referral, the In-Network Provider shall be permitted to provide and coordinate the specialty care for the Member's condition, including authorizing procedures, tests, and other medical services. The In-Network Provider may also refer the Member to another In-Network Provider for the condition for which the initial referral was obtained. The Referral does not authorize the In-Network Provider to assume the responsibilities for care other than for the condition for which the Referral was written.

### *Exceptions to Requirement for Primary Care Provider Referral.*

The following Covered Services do not require a Referral from a Primary Care Provider:

- In any case in which Covered Services are provided to the Member by any health care facility or health care practitioner (whether or not an In-Network Provider) for Urgent Care, Emergency Services or follow-up care after emergency surgery, without a Referral, benefits will be available for such services to the same extent as if such health care facility or Health Care Provider was obtained under Option 1.
- Outpatient Mental Health and Substance Abuse Services. Prior Authorization must be obtained from the Mental Health Management Program. See Section Two, Part H - Covered Services Requiring Prior Authorization.
- A Member may self-refer to In-Network Providers and receive Option 1 benefits in the following instances:
  - ▶ Covered gynecological and obstetric services from an In-Network Provider certified nurse midwife, In-Network Provider obstetrician/gynecologist or any other In-Network Provider that is a non-physician provider authorized under the Health Occupations Article to provide obstetric and gynecological services, **except** for infertility testing and diagnostic services.
  - ▶ Covered Services rendered at In-Network Provider radiologist offices whether ordered by an In-Network Provider or Out-of-Network Provider.
  - ▶ Covered Services rendered by an In-Network Provider laboratory whether ordered by an In-Network Provider or an out-of-network Health Care Provider that does not participate in the CareFirst BlueChoice Provider network (Out-of-Network Provider).
  - ▶ Covered diagnostic testing rendered by an In-Network Provider.
  - ▶ Prostate Cancer Screening, Colorectal Cancer Screening, Breast Cancer Screening, Chlamydia Screening Tests and Human Papillomavirus Screening Tests performed by In-Network Providers.
  - ▶ Well-Child Care, Adult Preventive Care and Immunizations performed by In-Network Providers.
  - ▶ Covered Services rendered by an In-Network Provider ophthalmologist for diagnosis and treatment for medical conditions of the eye.
  - ▶ Covered Services rendered by an In-Network Limited Service Immediate Care Center.
  - ▶ Covered Services rendered by an In-Network Mental Health and Substance Abuse Services Provider. Prior Authorization must be obtained from the Mental Health Management Program. See Section Two, Part H - Covered Services Requiring Prior Authorization. The contact information for the Mental Health Management Program is located on the Member's identification card.
  - ▶ Diabetic supplies provided by In-Network Providers.

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### *Standing or Condition Management Referral by your Primary Care Provider to a Specialist*

Under other circumstances, you may also obtain a Standing Referral or Condition Management Referral from your PCP to a Specialist:

- A Member may request a Condition Management Referral or a Standing Referral from the Primary Care Provider to a Specialist for a condition that:
  - ▶ Is life threatening, degenerative, chronic or disabling; or
  - ▶ Requires a Specialist over a prolonged period of time.
  - ▶ **NOTE:** Upon request for a Condition Management Referral, the Primary Care Provider will contact the Plan Administrator to obtain Prior Authorization.
- A Member who has been diagnosed with cancer may request a Standing Referral from their Primary Care Provider to a:
  - ▶ Contracting Physician who is a board-certified physician in pain management; or
  - ▶ Contracting Physician who is an oncologist.
  - ▶ **NOTE:** A Standing Referral does not authorize the Contracting Physician to assume the responsibilities for care other than cancer care and pain management. The Referral is subject to periodic review by the Primary Care Provider and the Plan Administrator.
- Standing Referral for Pregnancy.
  - ▶ A Member who is pregnant may obtain a Standing Referral to an obstetrician.
  - ▶ **NOTE:** After the Member who is pregnant receives a Standing Referral to an obstetrician, the obstetrician is responsible for the primary management of the Member's pregnancy, including the issuance of referrals in accordance with the Plan Administrator's policies and procedures, through the postpartum period.

### *Conditions for a Referral to a Specialist or a Non-Physician Specialist who is not an In-Network Provider.*

A Referral to a Specialist or a Non-Physician Specialist who is not an In-Network Provider shall be provided if the Member is diagnosed with a condition or disease that requires specialized health care services or medical care; and

- CareFirst BlueChoice does not contract with a Specialist or Non-Physician Specialist with the professional training and expertise to treat or provide health care services for the condition or disease; or
- CareFirst BlueChoice cannot provide reasonable access to a Specialist or Non-Physician Specialist with the professional training and expertise to treat or provide health care services for the condition or disease without unreasonable delay or travel.

For purposes of calculating any Deductible or Copayment amount payable by the Member, CareFirst BlueChoice will treat the services received by the Specialist or Non-Physician Specialist as if the service was provided by an Option 1 In-Network Provider.

A decision by CareFirst BlueChoice not to provide access to or coverage of treatment or health care services by a Specialist or Non-Physician Specialist in accordance with this provision constitutes an Adverse Decision as defined in this HMO Certificate of Coverage if the decision is based on a finding that the proposed service is not Medically Necessary, appropriate, or efficient. See Section Two, Part N - Notice of Initial Decisions and Procedures for Complaints, Grievances and Appeals.

When the Member uses an In-Network Provider under Option 1, benefits are based on the appropriate Allowed Benefit. The level of benefits is reflected in the Schedule of Benefits. In-Network Providers will accept 100% of the Allowed Benefit as full payment for Covered Services.

In-Network Providers will submit claims for services rendered directly to CareFirst BlueChoice.

### **Option 2**

In cases where a Referral would be required under Option 1, a Member may opt to obtain Covered Services from In-Network Providers without obtaining a Referral. When the Member obtains Covered Services in this manner, he or she is using the open access feature.

### *Open Access Feature*

Members do not need a Referral from a Primary Care Provider for office visits to In-Network Providers. However, certain In-Network Covered Services require Prior Authorization. See Section Two, Part H - Covered Services

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Requiring Prior Authorization. In-Network Providers will handle these Utilization Review Requirements on the Member's behalf. When Members obtain Covered Services in this manner, benefits will be considered Option 2.

When the Member uses an In-Network Provider under Option 2, benefits are based on the appropriate Allowed Benefit. The level of benefits is reflected in the Schedule of Benefits. In-Network Providers will accept 100% of the Allowed Benefit as full payment for Covered Services.

If the Member receives Covered Services from an In-Network Provider who is not the Member's Primary Care Provider without a Referral from the Member's Primary Care Provider where a Referral is required, the Member is charged the Copayment under Option 2 in the Schedule of Benefits. See Section Three, Part B – Schedule of Benefits.

Except for Mental Health and Substance Abuse Services, if the Member is hospitalized in an In-Network hospital and the Member's admitting physician is an In-Network Provider who has rendered Covered Services to the Member without a Referral from the Member's Primary Care Provider, Covered Services for the admission will be covered under Option 2. Inpatient Mental Health and Substance Abuse Services rendered by In-Network Providers will be covered under Option 1. **NOTE:** All medical and mental health/substance abuse inpatient admissions require Prior Authorization.

In-Network Providers will submit claims for services rendered directly to CareFirst BlueChoice.

### **Option 3**

Except as otherwise authorized by the Plan, Out-of-Network benefits will be provided under Option 3 when Covered Services are provided by a Health Care Provider who does not participate in the CareFirst Blue Choice network but who is a Health Care Provider who has contracted with CareFirst BlueCross Blue Shield (Participating Provider) or who has not contracted with either CareFirst BlueChoice or CareFirst BlueCross BlueShield (Non-Participating Provider). When Out-of-Network benefits apply, Covered Services are eligible for benefits under Option 3 as stated in the Schedule of Benefits. When the Member uses an Out-of-Network Provider under Option 3, benefits are based on the appropriate Allowed Benefit. Emergency Services, Urgent Care or follow-up care after emergency surgery when rendered by Out-of-Network Providers will be covered under Option 1.

#### *When Covered Services are rendered under Option 3*

##### Out-of-Network Participating Provider.

Out-of-Network Participating Providers will bill CareFirst BlueChoice directly for Covered Services. **The Member will not be responsible for amounts in excess of the Allowed Benefit for Covered Services, except any applicable Copayments, Coinsurance and Deductibles.** When Covered Services are rendered inside the Service Area, the Out-of-Network Participating Provider will make arrangements with CareFirst BlueChoice to obtain any Prior Authorization and Utilization Review approvals required for coverage. When Covered Services are rendered outside of the Service Area, the Member will be responsible for making arrangements with CareFirst BlueChoice to obtain Prior Authorization and Utilization Review approvals required for coverage. Refer to Section Two, Part H - Covered Services Requiring Prior Authorization, for Covered Services that require Prior Authorization.

##### Out-of-Network Non-Participating Provider.

**Out-of-Network Non-Participating Providers are not required to accept the Allowed Benefit as full payment and will collect additional amounts from the Member up to the Provider's full charges.** The Allowed Benefit may be substantially less than the Provider's actual charge to the Member. Therefore, when Covered Services are provided under Option 3, Members should expect to pay additional amounts to providers that exceed the Allowed Benefit.

##### Member Responsibilities.

Members are required to submit claims for Covered Services rendered by Out-of-Network Non-Participating providers to receive benefits. Members may have claims submitted by the Out-of-Network Non-Participating Provider on their behalf. A claim submitted by an Out-of-Network Non-Participating Provider on behalf of a Member must be submitted within the time frame granted to the Member to file the claim. Refer to Section Two, Part L – Filing a Claim, for claims submission requirements.

Members are responsible for providing all information requested by CareFirst BlueChoice with respect to claims for Covered Services provided by Out-of-Network Non-Participating Providers, including, but not limited to, medical records.

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Members are responsible for making arrangements with CareFirst BlueChoice to obtain Prior Authorization and Utilization Review approvals required for Covered Services received from Out-of-Network Non-Participating Providers and for Covered Services received outside the Service Area from Out-of-Network Participating Providers. Refer to Section Two, Part H - Covered Services Requiring Prior Authorization, for Covered Services that require Prior Authorization.

**NOTE:** If the member is hospitalized and the Member's admitting physician is an Out-of-Network Participating Provider or an Out-of-Network Non-Participating Provider, the entire course of treatment is considered Out-of-Network Option 3, even if the Member is admitted to an In-Network hospital.

### *Selecting a Primary Care Provider*

MHIP requires each Member joining the HealthyBlue Benefit Option to establish and maintain a relationship with a Primary Care Provider ("PCP"). A Primary Care Provider is a Contracting Physician or Contracting Provider who is part of the CareFirst BlueChoice Provider network and who is selected by a Member to provide and manage the Member's health care.

A Primary Care Provider can be any of the following types of Health Care Providers: Family Practice, General Practice, Internal Medicine, Obstetrics/Gynecology and/or Pediatrics. Your Primary Care Provider will coordinate all of your Health Care Services, except in the case of Emergency Services or Urgent Care.

A Member must select your Primary Care Provider from the current list of Contracting Providers in the CareFirst BlueChoice Provider network. If a specific Primary Care Provider is not available, the Plan Administrator will assist the Member in making another selection.

### *Changing Your Primary Care Provider*

If you have enrolled in the Healthy Blue Option, you must select a contracting Primary Care Provider. You will have the option to change your Primary Care Provider once a month during the Plan Year. You must contact Member Services at (443) 725-1010 or toll free at (888) 456-2024 to request the change. Requests for Primary Care Provider changes that are made prior to the fifteenth (15<sup>th</sup>) of the month will be effective on the first (1<sup>st</sup>) of the next month. Requests that are received on or after the fifteenth (15<sup>th</sup>) of the month will be effective on the first (1<sup>st</sup>) of the month that follows the next month.

## C. Provider Information

You can obtain information to identify the Health Care Providers who are a part of the CareFirst BlueChoice Provider network in the following ways:

- Visiting the MHIP website at [www.marylandhealthinsuranceplan.state.md.us](http://www.marylandhealthinsuranceplan.state.md.us) and clicking on "Provider Search;"
- Calling Member Services at (443) 725-1010 or toll free at (888) 456-2024; or
- Reviewing a printed CareFirst BlueChoice Provider Directory that you may have received with your enrollment materials.

**NOTE:** For Members of the HealthyBlue Benefit Options only, Out-of-Network Providers may participate in the CareFirst BlueCross BlueShield Preferred Provider network. Services provided by these Providers will be treated as Out-of-Network (Option 3) under the HealthyBlue Benefit Option.

## D. Medical Case Management

Case management services are used for a Member with a chronic condition, a serious illness, or complex health care needs. The Plan Administrator will initiate and perform case management services, as it deems appropriate, and these services may include the following:

- Assessment of Member/family needs related to the understanding of health status and physician treatment plans, self-care and compliance capability, and continuum of care;
- Education of Member/family regarding disease, treatment compliance and self-care techniques;
- Help with organization of medical care, including arranging for needed services and supplies, as appropriate

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- Assistance in arranging for a principal or primary Health Care Provider to deliver and coordinate the Member's care and/or consultation with one or more Specialists; and
- Referral of the Member to community resources.

### E. Primary Care Medical Home

Benefits will be provided for associated costs for coordination of care for the Qualifying Individual's medical conditions, including:

- Liaison services between the Qualifying Individual and the Health Care Provider(s), nurse coordinator, and the Care Coordination Team.
- Creation and supervision of the Care Plan, inclusive of an assessment of the Qualifying Individual's medical needs.
- Education of the Qualifying Individual/family regarding the Qualifying Individual's disease, treatment compliance and self-care techniques;
- Assistance with coordination of care, including arranging consultations with Specialists, and obtaining other Medically Necessary supplies and services, including community resources.
- The capitalized terms above have the following meanings:
  - ▶ Care Coordination Team means the Health Care Providers involved in the collaborative process of assessment, planning, facilitation and advocacy for options and services to meet the Member's health needs through communication and available resources to promote quality cost-effective outcomes.
  - ▶ Care Plan means the plan directed by a Health Care Provider, and coordinated by a nurse coordinator and Care Coordination Team, with engagement by the Qualifying Individual. The Care Plan is created in accordance with the PCMH goals and objectives.
  - ▶ Health Care Provider, as used in this amendment, means a physician, health care professional or health care facility licensed or otherwise authorized by law to provide Covered Services described in this amendment.
  - ▶ Primary Care Medical Home Program ("PCMH") means medical and associated services directed by the PCMH team of medical professionals to:
    - ✓ Foster the Health Care Provider's partnership with a Qualifying Individual and, where appropriate, the Qualifying Individual's primary caregiver;
    - ✓ Coordinate ongoing, comprehensive health care services for a Qualifying Individual; and,
    - ✓ Exchange medical information with CareFirst, other providers and Qualifying Individuals to create better access to health care, increase satisfaction with medical care, and improve the health of the Qualifying Individual.
  - ▶ Qualifying Individual means a Member with a chronic condition, serious illness or complex health care needs, as determined by CareFirst requiring coordination of health services and who agrees to participate in the Primary Care Medical Home Program.

**NOTE** Benefits provided through the Primary Care Medical Home Program are available only when provided by a CareFirst -approved Health Care Provider who has elected to participate in the CareFirst Primary Care Medical Home Program.

### F. Prevention and Wellness Information

From time to time, through Member newsletters, the MHIP website [www.marylandhealthinsuranceplan.state.md.us](http://www.marylandhealthinsuranceplan.state.md.us), or special mailings, MHIP may share information with you about prevention and wellness topics.

### G. Prior Authorization Requirements

Certain services will be covered only if you or your doctor obtains Prior Authorization for a Medically Necessary service. Under the Prior Authorization procedures applicable to your Benefit Options, the Plan must approve in advance coverage of certain Covered Services. The Plan conducts Utilization Review and makes Prior Authorization decisions by applying nationally recognized guidelines that apply to certain procedures and services. As described below, different Prior Authorization requirements apply to different Benefit Options.

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### Prior Authorization Process

This process ensures that Hospital, Skilled Nursing Facility and Hospice Care services, certain Outpatient procedures/services and prescription drugs are Medically Necessary.

Failure to follow the guidelines below could result in a reduction of or denial of claims for Covered Services:

Type of Service	Prior Authorization Procedure
<b>MEDICAL</b>	
Inpatient Hospitalization, Skilled Nursing Facility, Inpatient Hospice Care	Have your Provider contact the Plan Administrator for Prior Authorization at (866) PRE-AUTH (866-773-2884).
Outpatient Procedures and Services Requiring Prior Authorization (see Section Two, Part G – Covered Services Requiring Prior Authorization).	Have your Provider contact the Plan Administrator for Prior Authorization at (866) PRE-AUTH (866-773-2884).
Organ and Tissue Transplants	Have your Provider contact the Plan Administrator for Prior Authorization at (866) PRE-AUTH (866-773-2884).
<b>MENTAL HEALTH/SUBSTANCE ABUSE</b>	
Inpatient Treatment at a Facility	Have your Provider contact Magellan Health Services at (800) 245-7013.
Outpatient Services	Have your Provider contact Magellan Health Services at (800) 245-7013.
<b>PRESCRIPTION DRUGS</b>	
Certain prescription drugs require preauthorization	Have your Provider contact Argus Health Systems at (800) 314-2872.

If you have any questions regarding Prior Authorization for medical services or Prescription Drugs, please contact Member Services at (443) 725-1010 or toll free at (888) 456-2024.

## H. Covered Services Requiring Prior Authorization

The following Covered Services may require Prior Authorization. Contracting Providers will handle Prior Authorization procedures on behalf of Members of the HMO Benefit Option. In-Network Providers will handle Prior Authorization procedures under the Option 1 and Option 2 of the HealthyBlue Benefit Option. You are responsible for obtaining Prior Authorization for any Covered Services you obtain from any Non-Contracting Provider (where covered under the HMO Benefit Option) or Out-of-Network Provider (under Option 3 of the HealthyBlue Benefit Option). **NOTE:** Failure to obtain Prior Authorization, where required, could result in a reduction of or denial of claims for Covered Services.

COVERED SERVICE	PRIOR AUTHORIZATION REQUIRED?		
	HMO	HealthyBlue	
		Options 1 and 2 (In-Network)	Option 3 (Out-of-Network)
Outpatient Diagnostic and Surgical Procedures performed at a Hospital	YES	YES	YES
Ambulance Transport (Non-Emergency)	YES	NO	NO
Controlled Clinical Trials	YES	YES	YES
Dental Trauma	YES	YES	YES
Durable Medical Equipment and Disposable Medical Supplies -	YES	YES	YES
Home Health Care	YES	YES	YES

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COVERED SERVICE	PRIOR AUTHORIZATION REQUIRED?		
	HMO	HealthyBlue	
		Options 1 and 2 (In-Network)	Option 3 (Out-of-Network)
Hospice	YES	YES	YES
Hospital Inpatient admissions (all medical, surgical, rehabilitation or observation admissions)	YES	YES	YES
Infertility Testing and Diagnosis	YES	YES	YES
Mental Health and Substance Abuse Services (Inpatient and Outpatient services)	YES Contact Magellan Health Services at (800) 245-7013	YES Contact Magellan Health Services at (800) 245-7013	YES
Oral Surgery performed at a Hospital	YES	YES	YES
Organ and Tissue Transplants	YES	YES	YES
Orthotics	YES	YES	YES
Other Outpatient non-Emergency Health Care Services that were not (i) obtained from your PCP; (ii) the subject of a referral from your PCP; or (iii) eligible for self-referral as provided in Section Two, Part B of this Certificate (HMO Benefit Option Only)	YES	NO	NO
Prosthetics	YES	YES	YES
Reconstructive Surgery	YES	YES	YES
Skilled Nursing Facility	YES	YES	YES
Prescription Drugs	Certain drugs require preauthorization	Certain drugs require preauthorization	Certain drugs require preauthorization
Reconstructive Surgery	YES	YES	YES
Skilled Nursing Facility	YES	YES	YES

### I. Emergency Services

***In an Emergency, call 911 or go to the nearest Hospital Emergency Room.***

The Plan will cover Emergency Services for all Members without Prior Authorization.

Emergency Services are Covered Services that are rendered after the sudden onset of a medical condition that manifests itself by symptoms of such sufficient severity, including severe pain that, in the absence of immediate medical attention, a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect to result in:

- Serious jeopardy to the mental or physical health of the Member;
- Danger of serious impairment of the Member's bodily functions;
- Serious dysfunction of any of the Member's bodily organs; or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Examples might include, but are not limited to, heart attacks, uncontrollable bleeding, inability to breathe, loss of consciousness, poisonings, and other acute conditions as the Plan Administrator determines.

If you require hospitalization following Emergency Services, you or a family member must notify the Plan Administrator at (866) PRE-AUTH (866-773-2884), within 48 hours or as soon as it is reasonably possible. Your Health Care Provider will help to coordinate a transfer or the Plan Administrator will work with your Health Care Provider to arrange a transfer to a network Hospital when medically feasible and will also coordinate follow-up care.

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**NOTE:** The HMO Benefit Option generally does not cover Health Care Services rendered by a Non-Contracting Provider. However, if you are a Member of the HMO Benefit Option, and you require Emergency Services, you may obtain Emergency Services from a Non-Contracting Provider.

### J. Urgent Care

The Plan provides access to Urgent Care to all Members without Prior Authorization. Depending on your Benefit Option, an applicable Copayment or Coinsurance for Emergency Services or Urgent Care will apply. Covered Services include:

- Urgent Care at a physician's office or an Urgent Care facility,
- Emergency Services as an Outpatient or Inpatient at a Hospital (including physician services), and
- Emergency ambulance service.

The Plan will cover Urgent Care from a Contracting Provider without Prior Authorization.

**NOTE:** The HMO Benefit Option does not cover Health Care Services rendered by a Non-Contracting Provider, except for Emergency Services or Urgent Care and certain other services described in this Certificate of Coverage. If you are a Member of the HMO Benefit Option, and you require Urgent Care, you may obtain Urgent Care from a Non-Contracting Provider.

### K. Out-of-Area Care

#### Out-of-Area Services

CareFirst BlueCross BlueShield has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever Members access healthcare services outside the geographic area CareFirst serves, the claim for those services may be processed through one of these Inter-Plan Programs and presented to CareFirst for payment in accordance with the rules of the Inter-Plan Programs policies then in effect. The Inter-Plan Programs available to Members under this Certificate of Coverage are described generally below.

Typically, Members, when accessing care outside the geographic area CareFirst serves, obtain care from Health Care Providers that have a contractual agreement (i.e., are PPO/Participating") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, Members may obtain care from Non-Participating Providers. CareFirst payment practices in both instances are described below.

A Member will be entitled to benefits for Covered Services accessed either inside or outside the geographic area CareFirst serves. Some CareFirst products limit in-network benefits to certain services and/or cover only limited healthcare services received outside of CareFirst's service area, e.g., Emergency Services.

For purposes of the HMO and HealthyBlue Benefit Options, "Out-of-Area Covered Emergency Services" means:

1. Emergency Services;
2. Urgent Care;
3. Follow-up care after emergency surgery for services provided by the physician, surgeon, oral surgeon, periodontist, or podiatrist who performed the surgical procedure, for follow-up care that is Medically Necessary, directly related to the condition for which the surgical procedure was performed and provided in consultation with the Member's primary care provider ("PCP").

Member liability for Out-of-Area Covered Emergency Services is limited to the Member Payment for Emergency Services and Urgent Care as set forth in the Certificate of Coverage. All other Covered Services will be processed at the out-of-network level of benefits.

Due to variations in Host Blue network protocols, a Member may also be entitled to benefits for some healthcare services obtained outside the geographic area CareFirst serves, even though the Member might not otherwise have been entitled to benefits if he or she had received those healthcare services inside the geographic area CareFirst serves. But in no event will a Member be entitled to benefits for healthcare services, wherever he or she

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received them, that are specifically excluded from, or in excess of the limits of, coverage provided by this Certificate of Coverage.

### A. Definitions

For purposes of Inter-Plan Programs, the underlined terms, when capitalized, are defined as follows:

Allowed Benefit, unless otherwise stated, or required by federal law, means the amount the Host Blue allows for a Covered Service regardless of whether the amount the Host Blue allows is greater or lesser than CareFirst's Allowed Benefit and is deemed a final amount.

BlueCard PPO Network Provider (PPO Provider) means a Health Care Provider who contracts with a Host Blue as part of its Preferred Provider Organization (PPO) network.

BlueCard Traditional Network Provider (Participating Provider) means a Health Care Provider who contracts with a Host Blue to be paid directly for rendering Covered Services to Members.

Non-Participating Provider means any Health Care Provider that does not contract with a Host Blue.

Preferred Provider Organization (PPO) means a healthcare benefit arrangement designed to supply services at a discounted cost by providing incentives for Members to use designated Health Care Providers (who contract with the PPO at a discount), but which also provides coverage for services rendered by Health Care Providers who are not part of the PPO network.

### B. BlueCard® Program

Under the BlueCard® Program, when Members access Covered Services from a PPO Provider or Participating Provider within the geographic area served by a Host Blue, CareFirst will remain responsible to the Plan for fulfilling CareFirst contractual obligations. However, in accordance with applicable Inter-Plan Programs policies then in effect, the Host Blue will be responsible for providing such services as contracting and handling substantially all interactions with its PPO/Participating Providers. The financial terms of the BlueCard Program are described generally below. Individual circumstances may arise that are not directly covered by this description; however, in those instances, our action will be consistent with the spirit of this description.

Whenever a Member accesses Covered Services outside the geographic area CareFirst serves and the claim is processed through the BlueCard Program, the amount the Member pays for Covered Services, if not a flat dollar copayment, is calculated based on the lower of:

- The billed covered charges for the Covered Services; or
- The negotiated price that the Host Blue makes available to CareFirst.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Health Care Provider. Sometimes, it is an estimated price that takes into account special arrangements with the Health Care Provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of Health Care Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price CareFirst uses for a claim because they will not be applied retroactively to claims already paid.

A small number of states require Host Blues either (i) to use a basis for determining Member liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or (ii) to add a surcharge. Should federal law or the state in which healthcare services are accessed mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, CareFirst would then calculate Member liability and the Plan's liability in accordance with applicable law.

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Under certain circumstances, if CareFirst pays the Health Care Provider amounts that are the responsibility of the Member under this Certificate of Coverage CareFirst may collect such amounts from the Member.

### C. Non-Participating Providers Outside the CareFirst Service Area

#### Member Liability Calculation

##### 1. In General

When Covered Services are provided outside of the CareFirst service area by Non-Participating Providers, the amount(s) a Member pays for such services will generally be based on either the Host Blue's Non-Participating Provider local payment or the pricing arrangements required by applicable state/federal law. In these situations, the Member may be responsible for the difference between the amount that the Non-Participating Provider bills and the payment CareFirst will make for the Covered Services as set forth in this paragraph.

##### 2. Exceptions

In some exception cases, CareFirst may pay claims from Non-Participating Providers outside of CareFirst's service area based on the provider's billed charge, such as in situations where a Member did not have reasonable access to a PPO/Participating Provider, as determined by CareFirst in CareFirst's sole and absolute discretion or by applicable state/federal law. In other exception cases, CareFirst may pay such claims based on the payment it would make if CareFirst were paying a Non-Contracted Provider inside of its service area, as described elsewhere in this Certificate of Coverage, where the Host Blue's corresponding payment would be more than CareFirst's in-service area Non-Contracted Provider payment, or in CareFirst's sole and absolute discretion, CareFirst may negotiate a payment with such a provider on an exception basis.

Finally, CareFirst may pay up to billed charges for the Plan's designated Covered Services.

Unless otherwise stated, in any of these exception situations, the Member may be responsible for the difference between the amount that the Non-Participating Provider bills and the payment CareFirst will make for the Covered Services as set forth in this paragraph.

#### Inter-Plan Programs Eligibility Claim Types

Unless otherwise stated, all claim types are eligible to be processed through the Inter-Plan Programs except for those benefits that may be delivered by a third-party contracted by CareFirst to provide the specific service or services.

Out-of-Area Services	Benefit Level
Out-of-Area Covered Emergency Services	<b>All Inter-Plan Programs: In-Network</b>
	Member liability for Out-of-Area Covered Emergency Services is limited to the Member Payment for Emergency Services and Urgent Care as set forth in the Certificate of Coverage
All other Covered Services	<b>BlueCard® Program: Out-of-Network</b>
	When rendered by a BlueCard Traditional network or BlueCard PPO network provider:  Member liable up to the Allowed Benefit
	<b>Non-Participating Healthcare Providers: Out-of-Network</b>
	Member liable up to charge (balance billing permitted)

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### L. Filing a Claim

#### ***Medical Claims for Contracting or in-Network Providers***

##### *HMO Benefit Option*

Members enrolled in the HMO Benefit Option will not have any claims to submit to the Plan for Covered Services received from a Contracting Provider. The HMO Benefit Option does not cover Health Care Services rendered by a Non-Contracting Provider. The only exception may be if you obtain Emergency Services or Urgent Care (with Prior Authorization) from a Non-Contracting Provider. In this situation, if a Non-Contracting Provider requires you to pay for Emergency or Urgent Care Services at the time you receive them, you should follow the claim submission steps described below.

##### *HealthyBlue Benefit Option*

Members enrolled in the HealthyBlue Benefit Option who receive Covered Services under Option 3 from an Out-of-Network Provider who participates in the CareFirst BlueCross BlueShield's Preferred Provider network should present their MHIP identification card to the Provider. This Provider will take care of filing claims for you. You do not have to file claims yourself. The Plan Administrator pays this Provider for Covered Services under the Plan. You will owe this Provider only for the services not covered by the Plan and for any applicable Deductible or Copayment.

#### ***Claims for Medical Services by Non-Contracting or Out-of-Network Providers***

##### *HMO Benefit Option*

The HMO Benefit Option does not cover Health Care Services rendered by a Non-Contracting Provider who does not participate in the CareFirst BlueChoice provider network. The Plan **will not pay** claims by HMO Benefit Option Members for Covered Services provided by a Non-Contracting Provider, except in the cases of Emergency Services or Urgent Care noted in Section Two, Parts J and K, or unless you have received a referral from your Primary Care Provider and/or Prior Authorization for those Covered Services from the Plan. You have six (6) months from the date of service to submit any claim to the Plan Administrator. If allowed, your claim will be subject to any applicable Coinsurance or Copay.

##### *HealthyBlue Benefit Option*

Members enrolled in the HealthyBlue Benefit Option who receive Covered Services from an Out-of-Network Provider under Option 3 may be required to pay the Out-of-Network Provider at the time they receive the Covered Service. If you are required to pay for Covered Services at the time you receive them, you will need to file a reimbursement claim with the Plan Administrator. Send claims to the appropriate address listed under step 4 of this Section. Your claim will be subject to any applicable Deductible, Coinsurance or Copay. You have six (6) months from the date of service to submit any claim to the Plan Administrator. If you fail to submit your claim in this time frame, your claim may be denied.

**NOTE: Out-of-Network Providers are not required to accept the Plan's Allowed Benefit as payment in full for services rendered. You may receive a bill from an Out-of-Network Provider for the difference between the Plan payment and the Out-of-Network Provider's billed charges.**

**The difference between the Allowed Benefit and an Out-of-Network Provider's billed charges is not considered an eligible expense for the purposes of calculating any Deductible or Out-of-Pocket Maximum.**

**NOTE:** Allow 30 days for claim processing.

#### ***Follow the Steps Below to Submit a Claim Form for Medical or Mental Health Benefits***

##### *Step 1: Obtain a Health Benefits Claim Form*

Whenever possible, request a claim form before treatment begins. Claim forms are available on the MHIP website at [www.marylandhealthinsuranceplan.state.md.us](http://www.marylandhealthinsuranceplan.state.md.us) on the "Forms" page or by calling Member Services at (443) 725-1010 or toll free at (888) 456-2024.

##### *Step 2: Complete the Health Benefits Claim Form*

To assist in processing claims as quickly as possible, you must complete all information requested on the claim form. Sign your claim and attach any necessary information. You must complete a separate form for each family member that is submitting a claim.

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### *Step 3: Attach Related Items to the Health Benefits Claim Form*

When filing your claim, you must submit the following information to the Plan Administrator:

- The Provider's itemized bill showing:
  - ▶ Letterhead stating the name and address of the person or organization providing the service;
  - ▶ The name of the patient receiving the service;
  - ▶ The date for each individual service (a range of dates cannot be accepted);
  - ▶ The description of, and reason for, the service, including diagnostic and/or service codes; and
  - ▶ The charge for each individual service.
  
- Supporting information, as described on the Health Benefits Claim Form, if your claim is for the following services:
  - ▶ Emergency or Urgent Care services;
  - ▶ Treatment of Accidental Injury;
  - ▶ Prescription Drugs;
  - ▶ Prosthetic appliances and the rental or purchase of Durable Medical Equipment; or
  - ▶ Psychotherapy.

In addition, if you are covered by another insurance carrier for the services for which you seek reimbursement, you must provide the explanation of benefits provided by that carrier for that service.

**NOTE:** *If the above information does not accompany your claim form, your claim may not be processed.*

### *Step 4: Submit the Health Benefits Claim Form*

Mail the claim form and all supporting documentation to the Plan Administrator to:

Mail Administrator  
PO Box 14116  
Lexington, KY 40512

Be sure to keep copies of all documents you submitted, including forms, bills, explanation of benefits (EOB) statements, and receipts for your own records.

### ***Pharmacy Claims for Covered Prescriptions at a Non-Participating Pharmacy***

If you purchase covered prescriptions at a non-participating pharmacy and are required to pay the full cost of the Prescription Drugs, you will need to file a pharmacy claim in order to be reimbursed subject to the terms of the Plan's Prescription Drug program. Your claim will be subject to any applicable Deductible or Copay. You have twelve (12) months from the date of service to submit a pharmacy claim to the Plan Administrator. If you fail to submit your claim in this time frame, your claim may be denied.

### **Follow the steps below to file a Pharmacy Claim:**

#### *Step 1: Obtain a Direct Reimbursement Claim Form*

Direct Reimbursement Claim Forms are available on the MHIP website [www.marylandhealthinsuranceplan.state.md.us](http://www.marylandhealthinsuranceplan.state.md.us) or by calling Member Services at (443) 725-1010 or toll free at (888) 456-2024.

#### *Step 2: Complete the Direct Reimbursement Claim Form*

To assist in processing claims for Prescription Drugs as quickly as possible, you must include all information requested on the Direct Reimbursement Claim Form. Ask the pharmacy that dispensed the Prescription Drug to complete the information in Part Three of the Direct Reimbursement Claim Form and to sign the form if required. Sign your Direct Reimbursement Claim Form and attach the requested documentation.

#### *Step 3: Attach Related Items to the Direct Reimbursement Claim Form*

When filing a pharmacy claim, you must submit the following documentation to Argus Health Systems. Argus Health Systems is an independent company and administers the Prescription Drug program on behalf of the Plan Administrator:

- Your pharmacy receipt showing:

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- ▶ Date of service;
- ▶ Medication received;
- ▶ Rx number;
- ▶ NDC Number;
- ▶ Drug strength;
- ▶ Number of days supplied;
- ▶ Quantity received; and
- ▶ Amount paid.

Submit a separate Direct Reimbursement Claim Form for each non-participating pharmacy from which you purchased Prescription Drugs.

### *Step 4: Submit the Direct Reimbursement Claim Form*

Mail the Direct Reimbursement Claim Form to:

Argus Health Systems  
PO Box 41909  
Kansas City, MO 64141

Be sure to keep copies of all documents you submitted, including forms, bills, Explanation of Benefits (EOB) statements, and receipts for your own records.

## M. Claim Processing

When you submit a claim for reimbursement of Covered Services, the Plan Administrator will determine if you were eligible for benefits on the service date(s) and calculate the amount of benefit payable, if any. After the claim is processed, you will receive an Explanation of Benefits (EOB) statement from the Plan Administrator. This statement explains how benefits are determined, and, if appropriate, will include a reimbursement check for some or all of the charges paid by you for services or supplies covered by the Plan.

The Plan Administrator permits assignment of Plan benefits to any Health Care Provider whose services or supplies are the basis of the claim, or to you if you furnish evidence acceptable to the Plan Administrator that you paid some or all of those costs. At your request, the Plan Administrator may, at its discretion, pay benefits directly to any Health Care Provider who provided the services or supplies on which a claim is based, and to whom you assigned your ability to receive payment for benefits. However, the Plan may pay those Plan benefits to you at its discretion. Plan benefits will be paid up to the amount allowed under the Plan. When Deductibles, Coinsurance or Copays apply, you are responsible for paying your share of those costs.

### ***Payment of Benefits***

For Covered Services under the Plan, the Allowed Benefit is based on the allowable charge for such services, as determined by the Plan. Contracting Providers and In-Network Providers accept the Plan's payment amount as payment in full *plus* any applicable Copay or Coinsurance and agree to make no additional charge to you for Covered Services. In addition, certain Out-of-Network Providers who participate in the CareFirst BlueCross BlueShield Preferred Provider network accept the Plan's payment amount as payment in full *plus* any applicable Copay or Coinsurance and agree to make no additional charge to you for Covered Services.

**Note: Out-of-Network Providers are not required to accept the Plan's Allowed Benefit as payment in full for services rendered. You may receive a bill from an Out-of-Network Provider for the difference between the Plan payment and the Provider's billed charges.**

**The difference between the Allowed Benefit and an Out-of-Network Provider's billed charges is not considered an eligible expense for the purposes of calculating any Deductible or Out-of-Pocket Maximum.**

### ***Facility of Payment***

If the Plan Administrator determines that you cannot submit a claim or prove that you paid any or all of the charges for Health Care Services that are covered by the Plan because you are incompetent, incapacitated, or in a coma, the Plan Administrator may, in its sole discretion, pay Plan benefits directly to the Health Care Provider(s) who provided the services, or to any other individual who is providing for your care and support. The Plan Administrator will not be responsible for the disposition of the money so paid.

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### ***Privacy, Confidentiality, Release of Records, or Information***

Any information collected by the Plan or Plan Administrator will be treated confidentially and will not be disclosed to anyone without your written consent, except as follows:

- Information will be disclosed to those who require that information to administer the Plan to confirm eligibility, coordinate treatment, authorization or to process claims and issue payments.
- Information with respect to duplicate coverage will be disclosed to the Plan or insurer that provides duplicate coverage.
- Information needed to determine if Health Care Services or supplies are Medically Necessary or if the charges for them are usual and customary will be disclosed to the individual or entity consulted to assist the Plan or its designee to make those determinations.
- Information will be disclosed as required and allowed by HIPAA, state and federal law or regulation or in response to a duly issued subpoena.

## **N. Notice of Initial Decisions and Procedures for Complaints, Grievances and Appeals**

This portion of the Certificate describes how you will be notified of certain Plan decisions and the procedures to follow if you want a decision reviewed by filing a Complaint, Grievance or Appeal. The following table summarizes the types of decisions and their corresponding options for review that are covered in this part of the Certificate:

<b><i>Initial Decision</i></b>	<b><i>Internal Review</i></b>	<b><i>Decision on Review</i></b>	<b><i>External Review</i></b>
Adverse Decision (Service Not Medically Necessary, Appropriate or Effective; Experimental/Investigational; Cosmetic)	Non-Emergency Case: Grievance (May Proceed Directly to Level Two Review for Compelling Reason)	Grievance Decision	Complaint to Insurance Commissioner
	Emergency Case: Expedited Review	Grievance Decision	Complaint to Insurance Commissioner
Coverage Decision (Service Not Covered or Payment Denied)	Appeal (May Proceed Directly to Review Level Two for Urgent Care not Already Rendered)	Appeal Decision	Complaint to Insurance Commissioner
Denial of Eligibility, Termination of Coverage for Non-Eligibility, Non-Payment, Fraud or Misrepresentation, or Denial of Change in Benefit Options	Appeal	Appeal Decision (Plan)	Appeal Decision (MHIP Board of Directors)

### ***Definitions***

MHIP uses the following terms when describing your right to receive notice of certain Plan decisions and how to have them reviewed:

“Adverse Decision” means a Utilization Review determination that a (i) proposed or delivered Health Care Service that is otherwise a Covered Service is not or was not Medically Necessary, appropriate or efficient, Experimental/Investigational, or Cosmetic; and (ii) may result in non-coverage of the Health Care Service. Adverse Decisions do not include determinations about a person’s eligibility status as a Member.

“Appeal” means a protest filed by you or your Health Care Provider on your behalf regarding a Coverage Decision, a Termination of Coverage for Non-Eligibility or Non-Payment or a Denial of Change in Benefit Options.

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“Appeal Decision” means a final determination from an Appeal of a Coverage Decision, or the Plan Administrator’s determination about appeals relating to Denial of Eligibility, Termination of Coverage for Non-Eligibility or Non-Payment or Denial of Change in Benefit Options.

“Complaint” means a protest filed with the Maryland Insurance Commissioner involving an Adverse Decision, Coverage Decision, Appeal Decision or Grievance Decision.

“Coverage Decision” means an initial determination that results in non-coverage of a Health Care Service. A Coverage Decision includes nonpayment of all or any part of a claim. It does not include an Adverse Decision.

“Emergency Case” means a case involving an Adverse Decision for which an expedited review is required for services proposed, but not delivered, and the services proposed are necessary to treat a condition or illness that without immediate medical attention would seriously jeopardize your life or health or your ability to regain maximum function or would cause you to be a danger to yourself or others. A designated Registered Nurse will determine whether an Emergency Case exists.

“Filing Date” means the earlier of (i) Five (5) days after the date of mailing; or (ii) the date of receipt.

“Grievance” means a protest filed by you or your Health Care Provider on your behalf regarding an Adverse Decision.

“Grievance Decision” means a final determination from a Grievance of an Adverse Decision.

“Health Advocacy Unit” means the Health Education and Advocacy Unit in the Division of Consumer Protection of the Office of the Attorney General.

### ***Notice of Decision***

The following describes how you will be notified of a Plan decision and the procedures for Complaints, Grievances and Appeals.

### ***Notice of Adverse Decision***

For an Adverse Decision on a non-Emergency Case, the decision will be orally communicated to you or a Health Care Provider acting on your behalf. In addition, within five (5) working days of the date of the Adverse Decision, a written notice will be sent to you and/or the Health Care Provider acting on your behalf. The notice will include:

- The specific factual basis for the decision stated in detail in clear, understandable language;
- A reference to the specific criteria and standards, including any interpretive guidelines, on which the Adverse Decision was based;
- The name, business address, and business telephone number of the representative responsible for the Grievance process;
- The Grievance process and procedures;
- A statement that you or your Health Care Provider acting on your behalf may, within thirty (30) working days after receiving the notice of a Grievance Decision, file a Complaint with the Maryland Insurance Commissioner, at the address listed below:

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

- A statement that you or your Health Care Provider acting on your behalf may file a Complaint with the Maryland Insurance Commissioner, without first filing a Grievance, if sufficient information and supporting documentation is filed with the Complaint that demonstrates a compelling reason to do so. A compelling reason must include information indicating that the potential delay in receiving the Health Care Service until after you or your Health Care Provider acting on your behalf has obtained a Grievance Decision could

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result in (i) your loss of life; (ii) serious impairment to a bodily function; (iii) serious dysfunction of a bodily organ; or (iv) you remaining seriously mentally ill with symptoms that cause you to be a danger to yourself or others; and

- A statement advising you or your Health Care Provider acting on your behalf that the Health Advocacy Unit (i) is available to assist you with filing a Grievance even though the unit is not available to represent or accompany you during the procedures of the internal Grievance process; and (ii) can assist you in mediating a resolution of the Adverse Decision with the carrier, but that any time during the mediation, you or your Health Care Provider acting on your behalf may file a Grievance. You may contact the Health Advocacy Unit as follows:

Health Education and Advocacy Unit  
Consumer Protection Division  
Office of the Attorney General  
200 St. Paul Place, 16<sup>th</sup> Floor  
Baltimore, MD 21202  
Fax: (410) 576-6571  
Phone: (410) 528-1840 or (877) 261-8807 (toll free)  
Email: [heau@oag.state.md.us](mailto:heau@oag.state.md.us)

### *Notice of a Coverage Decision*

Within thirty (30) calendar days of a Coverage Decision, written notice of the decision will be sent to you. The notice will include:

- The specific factual basis for the decision stated in detail in clear, understandable language;
- A statement that you or your Health Care Provider acting on your behalf may submit an Appeal of the Coverage Decision, in writing, to the following address:

Mail Administrator  
PO Box 14116  
Lexington, KY 40512  
Phone: (443) 725-1010 or (888) 456-2024 (toll free)

- A statement that if the Coverage Decision involves an urgent medical condition for which care has not been rendered, you or your Health Care Provider acting on your behalf may file a Complaint with the Maryland Insurance Commissioner, without first filing an Appeal at the address or phone number described above. A Complaint to the Commissioner can be submitted to:

Maryland Insurance Administration  
Life and Health Consumer Complaint Unit  
200 St. Paul Place  
Suite 2700  
Baltimore, MD 21202  
Fax: (410) 468-2270  
Phone: (410) 468-2000 or (800)492-6116  
TDD Users should use (800) 735-2258

- A statement that you or your Health Care Provider acting on your behalf may contact the Health Advocacy Unit to assist you in both mediating and filing an Appeal. The statement will include the following address, telephone number, facsimile number, and e-mail address of the Health Advocacy Unit:

Health Education and Advocacy Unit  
Consumer Protection Division  
Office of the Attorney General  
200 St. Paul Place, 16<sup>th</sup> Floor  
Baltimore, MD 21202  
Fax: (410) 576-6571  
Phone: (410) 528-1840 or (877) 261-8807 (toll free)  
Email: [heau@oag.state.md.us](mailto:heau@oag.state.md.us)

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### **Procedure for Filing a Grievance or Appeal**

#### *Filing a Grievance of an Adverse Decision*

You or your Health Care Provider acting on your behalf may file a Grievance for reconsideration of an Adverse Decision within one hundred eighty (180) days after receipt of the of the Adverse Decision. A Grievance may be submitted in writing to:

Mail Administrator  
PO Box 14116  
Lexington, KY 40512  
Phone: (443) 725-1010 or (888) 456-2024 (toll free)

The Grievance should contain sufficient information for an investigation and a decision. A Grievance will be handled as follows:

- All of the information submitted by you or your Health Care Provider acting on your behalf and any additional information about the case received by MHIP or the Plan Administrator will be reviewed. If there is insufficient information available to make a decision, you or your Health Care Provider who filed a Grievance on your behalf will be notified within five (5) working days of the Filing Date of the Grievance of the need for additional information. You or your Health Care Provider who filed a Grievance on your behalf will receive reasonable assistance to obtain the information without delay.  
**For example**, if it is necessary to obtain medical records or other information required for the review, you will receive an authorization release form.
- Within thirty (30) working days of the filing of the Grievance, the Grievance Decision will be orally communicated to you or your Health Care Provider who filed the Grievance on your behalf. Within five (5) working days of the date of the decision, written notice of the Grievance Decision will be sent to you and your Health Care Provider who filed the Grievance on your behalf. The notice will include:
  - ▶ The basis for the decision stated in detail in clear, understandable language;
  - ▶ A reference to the specific criteria and standards, including interpretive guidelines, on which the Grievance Decision was based;
  - ▶ The name, business address, and business telephone of the representative responsible for the Grievance process;
  - ▶ A statement that you may file a Complaint with the Maryland Insurance Commissioner, at the address listed below, within thirty (30) working days after receipt of the Grievance Decision:

Maryland Insurance Administration  
Appeal and Grievance Unit  
200 St. Paul Place  
Suite 2700  
Baltimore, MD 21202-2272  
Fax: (410) 468-2270  
Phone: (410) 468-2000 or (800) 492-6116  
TTY Users should use (800) 735-2258

#### *Requesting Expedited Review of an Adverse Decision*

You or your Health Care Provider acting on your behalf may request an expedited review of an Emergency Case, orally or in writing, when an Adverse Decision is rendered for Health Care Services that are proposed but have not been delivered and the services are:

- Necessary to treat a condition or illness that without immediate medical attention would seriously jeopardize your life or health or your ability to regain maximum function; or
- Would cause you to be a danger to yourself or others. A designated Registered Nurse will determine whether an Emergency Case exists.

An Expedited Review of an Adverse Decision will be handled as follows:

- An expedited review of an Adverse Decision will be performed by a physician advisor, a peer of the Health Care Provider, or a panel of other appropriate Health Care Providers at least one of which is a physician advisor and who was not involved with the initial review and determination of the Adverse Decision.
- An expedited review of an Adverse Decision will be completed within twenty-four (24) hours of the time you or your Health Care Provider acting on your behalf initiates the request. You may file a Complaint with the

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Maryland Insurance Commissioner if the expedited review is not completed within twenty-four (24) hours of the request.

- Within one (1) day after a decision has been orally communicated to you or your Health Care Provider acting on your behalf, a written notice will be sent to you and your Health Care Provider. The notice will include:
  - ▶ The specific factual basis for the decision stated in detail in clear, understandable language;
  - ▶ A reference to the specific criteria and standards, including interpretive guidelines, on which the expedited review was based;
  - ▶ The name, business address and business telephone number of the representative responsible for the Grievance process;
  - ▶ A statement that you or your Health Care Provider acting on your behalf may, within thirty (30) working days of receipt of the Grievance Decision, file a Complaint with the Maryland Insurance Commissioner, at the address below:

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

**NOTE:** An expedited review is not available for retrospective review of services that did not receive Prior Authorization.

### *Filing an Appeal of a Coverage Decision*

You or your Health Care Provider acting on your behalf may file an Appeal for reconsideration of a Coverage Decision within one hundred eighty (180) days after receipt of a Coverage Decision. An Appeal of a Coverage Decision may be submitted in writing to:

Mail Administrator  
PO Box 14116  
Lexington, KY 40512  
Phone: (443) 725-1010 or (888) 456-2024 (toll free)

The Appeal should contain sufficient information for an investigation and a decision. An Appeal will be handled as follows:

- Within sixty (60) working days after of the filing of the Appeal, the Appeal Decision will be orally communicated to you or your Health Care Provider who filed the Appeal on your behalf. Within thirty (30) calendar days after the date of the decision, written notice of the Appeal Decision will be sent to you and your Health Care Provider acting on your behalf. The notice will include:
  - ▶ The specific factual basis for the decision stated in detail in clear, understandable language;
  - ▶ A statement that you may file a Complaint with the Maryland Insurance Commissioner at the address listed below, within sixty (60) working days after receipt of the Appeal Decision:

Maryland Insurance Administration  
Life and Health Consumer Complaint Unit  
200 St. Paul Place  
Suite 2700  
Baltimore, Maryland 21202  
Fax: (410) 468-2270  
Phone: (410) 468-2000 or (800) 492-6116  
TDD Users should use (800) 735-2258

### ***Filing an Appeal of Denial of Eligibility, Termination of Coverage for Non-Eligibility, Non-Payment of Premium, or Denial of Change in Benefit Options***

You may request an Appeal of the Plan's denial of your eligibility, termination of your coverage for non-eligibility or non-payment of Premium, or a denial of your request to change your Benefit Option. An Appeal of these decisions

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may be submitted in writing within thirty (30) working days of the initial denial to:

Mail Administrator  
PO Box 14116  
Lexington, KY 40512  
Phone: (443) 725-1010 or (888) 456-2024 (toll free)

The Appeal should contain sufficient information for an investigation and a decision. An Appeal will be handled as follows:

- Within thirty (30) working days of the filing of the Appeal, a representative of the Plan Administrator will be consulted and review your request.
- Within seven (7) working days of the date of a decision, written notice of the Appeal Decision will be sent to the applicant. The notice will include:
  - ▶ The nature of the Appeal and issues involved;
  - ▶ The reason(s) supporting the decision, including a clear explanation in understandable language of the references used to make the decision, such as applicable statutes, regulations and standards on which the decision was based;
  - ▶ If the Plan Administrator upholds the initial determination of non-eligibility, a statement that you have the right to request a second-level Appeal of the decision from the Board of Directors of the Maryland Health Insurance Plan within 30 working days of receiving the written notice.

If you want a second-level Appeal conducted by the Board of Directors of the Maryland Health Insurance Plan, you must send your request in writing within 30 working days of receiving notice of the Plan's Appeal Decision to:

Board of Directors of the Maryland Health Insurance Plan  
201 E. Baltimore Street  
Box # 4  
Baltimore, MD 21202  
Attention: Member Appeals

Your Appeal will then be reviewed by the Board of Directors of the Maryland Health Insurance Plan. MHIP will notify you within 30 days of their decision about your Appeal.

If you believe that the decision of the Board of Directors is incorrect, you may request a hearing within 30 days after receipt of the decision. To request a hearing, you must send a written request for a hearing by mail or fax to:

Maryland Health Insurance Plan  
Hearing Request  
201 E. Baltimore Street  
Box #4  
Baltimore, MD 21202  
Fax: (410) 625-9202

### ***Obtaining Medical Records***

Maryland law permits you to ask for a copy of your medical records from the Health Care Providers who treat you. Your request must be in writing and must specify who you want to receive the records. The Health Care Provider who has your records will provide you or the person you specify with a copy of your records. A Health Care Provider may charge you to receive copies of your records.

### ***Designated Decision Maker***

If you have a designated health care decision-maker, that person must send a written request to the Plan to obtain access to, or for copies of, your medical records. The medical records must be provided to your health care decision-maker or a person designated in writing by your health care decision-maker.

### ***Confidentiality***

If you file a Grievance or an Appeal, the relevant portions of your medical records may be disclosed only to individuals authorized to participate in the review process for the medical condition under review. These individuals may not disclose your medical information to anyone else.

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### ***Receipt of Documents***

Any written notice, acknowledgement, request, decision, or other written document required to be mailed is deemed received by the person to whom the document is properly addressed on the 5<sup>th</sup> business day after being mailed. "Properly addressed" means the person's last known address.

## **O. Coordination of Benefits (COB)**

### ***Definitions***

MHIP uses the following terms when describing the coordination of benefits process under the Plan:

"Allowable Expenses" means a Health Care Service or expense, including an expense that is applied to a Deductible, Coinsurance or a Copayment, that is covered at least in part by any of the health plans covering the Member, except as set forth below. An expense, service, or portion of an expense or service that is not covered by any of the Member's health plans is not an allowable expense. When a health plan provides benefits in the form of services, (for example a health maintenance organization) the reasonable cash value of each service shall be considered an allowable expense and a benefit paid.

For example, the following expenses or Health Care Services are not considered an Allowable Expense:

- The difference between the cost of a private Hospital room and the cost of a semiprivate Hospital room, (unless the patient's stay in a private Hospital room is Medically Necessary in terms of generally accepted medical practice, or one of the health plans routinely provides coverage for private Hospital rooms) is not an Allowable Expense.
- If a Member is covered by two or more health plans, then the amount in excess of this Plan's usual and customary rate for a specific benefit is not an Allowable Expense. .

"Health plan" means any of the following that provides benefits or services for medical care, dental care, or health treatment:

- Group insurance contracts and group subscriber contracts;
- Self-insured arrangements of group or group-type coverage;
- Individual insurance contracts;
- Individual or group nonprofit health service plan contracts;
- Individual or group health maintenance organization contracts;
- The medical components of long-term care insurance, such as skilled nursing care; and
- Coverage under a government health plan, including Medicare (but excluding Medicaid).

"Health plan" does not include:

- Hospital indemnity benefit of \$200 per day or less;
- An individually underwritten and issued guaranteed renewable, specified disease policy that does not provide benefits on an expense incurred basis;
- An individually underwritten and issued guaranteed renewable, intensive care policy that does not provide benefits on an expense incurred basis;
- School accident-type coverage; and
- Coverage regulated by a motor vehicle reparation law, including personal injury protection (PIP) coverage under a motor vehicle insurance policy.

"Intensive care policy" means a health insurance policy that provides benefits only for treatment received in the specifically designated facility of a Hospital that provides the highest level of care and is restricted to patients who are physically and critically ill or injured.

"Primary health plan" means a health plan whose benefits for a Member's health care coverage must be determined without taking into consideration the existence of any other health plan. A health plan is a primary health plan if:

- The health plan either has no order of benefit determination rules, or its rules differ from those described below; or

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- All health plans that cover the individual use the order of benefit determination rules described below, and under those rules the health plan determines its benefits first.

"Secondary health plan" means a health plan is not a primary health plan. If a Member is covered by more than one secondary health plan, the order of benefit determination rules of this Plan decide the order in which secondary health plan benefits are determined in relation to each other. Each secondary health plan shall take into consideration the benefits of the primary health plan(s) and the benefits of any other health plan, which, under the rules set forth below, has its benefits determined before those of that secondary health plan.

"School accident-type coverage" means an insurance policy that covers students for accidents only, including athletic injuries, either on a 24-hour basis or on a "to and from school" basis.

"Specified disease policy" means a health insurance policy that provides:

- Benefits only for a disease or diseases specified in the policy or for a treatment unique to a specified disease or diseases; or
- Additional benefits for a disease or diseases specified in the policy or for treatment unique to a specified disease or diseases.

### **Coordination with Other Coverage**

You are not eligible to receive or to continue to receive MHIP coverage if you are eligible for or receiving Medicare, Medicaid or MCHP; have access to or enrolled in comparable group insurance; or enrolled in substantially similar individual insurance coverage. (See Section One, Part E – When Coverage Ends). This section, *Coordination of Benefits*, should not be interpreted to imply eligibility for MHIP under any circumstances not authorized by the Board of Directors of the Maryland Health Insurance Plan. See COMAR 31.17.03.14 (and related regulations).

Coordination of Benefits (COB) applies to this Plan, if you in fact have health care coverage under more than one health plan and the Plan's application of COB rules does not grant or imply eligibility and does not prevent your termination from the Plan in accordance with Section One, Part E of this Certificate. If the COB provision applies, the order of benefit determination rules will apply. These rules provide guidance on whether the benefits of this Plan are determined before or after those of another health plan.

The benefits of this Plan shall not be reduced when, under the order of determination rules, this Plan determines its benefits before another health plan; but may be reduced when, under the order of determination rules, another health plan determines its benefits first. The reduction of benefits is described in the "Effect on the Benefits of This Plan" section that follows.

### **Order of Determination Rules**

When there is a basis for a claim under this Plan and under another health plan, this Plan shall be a secondary plan which has its benefits determined after those of the other health plan, unless:

- The other health plan has rules coordinating benefits with those of this Plan; and
- Both the rules of the other health plan and this Plan require that this Plan's benefits be determined before those of the other health plan.

*THIS PLAN DETERMINES ITS ORDER OF BENEFITS USING THE FIRST OF THE FOLLOWING RULES THAT APPLIES:*

*Non-dependent/dependent* – The benefits of the health plan that covers the individual as a primary Subscriber shall be determined before those of the health plan that covers the individual as a dependent.

*Dependent child/parents not separated or divorced* – Except as stated below, when this Plan and another health plan cover the same child as a dependent of different parents:

- The benefits of the health plan of the parent whose birthday falls earlier in a year are determined before those of the health plan of the parent whose birthday falls later in the year; or
- If both parents have the same birthday, the benefits of the health plan that covered the parent longest shall determine its benefits first.
- However, if the other health plan does not have the rule described above, but instead has a rule based upon the gender of the parent, and if as a result, the health plans do not agree on the order of benefits, the rule in the other health plan will determine the order of benefits.

*Dependent child/parents separated or divorced* –

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- If the court decree states that one of the parents is responsible for the health care expenses or health insurance coverage of the child, and the health plan of that parent has actual knowledge of those terms, that plan is the primary health plan. If the parent with responsibility does not have health insurance coverage for the dependent child, but that parent's spouse does, the spouse's health plan is the primary health plan. This shall not apply with respect to any claim determination period or Plan Year during which benefits are paid or provided before the health plan has actual knowledge of the terms of the court decree.
- If the court decree states that both parents are responsible for the dependent child's health care expenses or health insurance coverage, the order of determination for dependent child/parents not separated or divorced as stated above shall apply.
- 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 insurance coverage of the dependent child and the dependent child's residency is split between the parents, the order of benefit determination shall be determined in accordance with the order of determination for dependent child/parents not separated or divorced as stated above.
- If there is no court decree allocating responsibility for the child's health care expenses or health insurance coverage, and two or more health plans cover an individual as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
  - ▶ First, the health plan that covers the custodial parent;
  - ▶ Second, the health plan of the spouse of the custodial parent;
  - ▶ Third, the health plan of the non-custodial parent; and
  - ▶ Fourth, the health plan of the spouse of the non-custodial parent.

If both parents share custodial care, the order of determination for dependent child/parents not separated or divorced as stated above shall apply.

### *Active or Inactive Employee –*

- The benefits of a health plan that covers an employee who is neither laid off nor retired are determined before those of a health plan that covers that individual as a laid off or retired employee.
- If the other health plan does not have this rule, and if, as a result, the health plans do not agree on the order of benefits, this rule is ignored.
- Coverage provided to an individual as a retired employee and coverage provided as a dependent of an active employee shall be determined under order of determination rule above.

### *Longer/Shorter Length of Coverage –*

- If none of the above rules determines the order of benefits, the health plan that covered the Member for the longer period of time is the primary health plan.
- To determine the length of time an individual has been covered under a health plan, two plans shall be treated as one if the individual was eligible under the second health plan within 24 hours after the first health plan ended.
- The start of the new health plan does not include:
  - ▶ A change in the amount or scope of a health plan's benefits;
  - ▶ A change in the entity that pays, provides or administers the health plan's benefits; or
  - ▶ A change from one type of health plan to another, such as from a single employer plan to that of a multiple employer plan.
- The individual's length of time covered under a plan is measured from the individual's first date of coverage under that health plan. If the date is not readily available for a group plan, the date the individual first became a Member shall be used as the date from which to determine the length of time the individual's coverage under the present health plan has been in force.

If none of the preceding rules determines the order of benefits, the Allowable Expenses shall be shared equally between the health plans.

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

This section applies when, in accordance with the order of determination rules, this Plan is a secondary health plan as to one or more other health plans. In that event, the benefits of this Plan may be reduced under this section.

The benefits of this Plan shall be reduced when the plan's allowable expense in a claim determination period exceeds the sum of:

## Section Two – How The Plan Works

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- the benefit that would be payable for the Allowable Expense under this Plan, in the absence of this COB provision; and
- the benefit that would be payable for the Allowable Expense under the other health plans, in the absence of provisions with a purpose like that of this COB provision

In that case, the benefits of this Plan will be reduced so that the benefits under this Plan and the benefits payable under the other health plans do not total more than this Plan's Allowable Expense. When the benefits of this Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

**NOTE:** The Plan will not reduce, limit, or exclude coverage due to payments to a Member under the Member's Personal Injury Protection Policy (or "PIP"). PIP is insurance coverage without regard to fault provided under a Member's motor vehicle insurance policy.

### ***Right to Receive and Release 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 health plans. MHIP or the Plan Administrator may get the facts it needs from or give them to other health plan which MHIP reasonably believes covers the Member during the relevant time period, for the purpose of applying these rules and determining benefits payable under this Plan and other health plans covering the Member claiming benefits. MHIP or the Plan Administrator need not tell, or get the consent of, any person to do this. Each Member claiming benefits under this Plan must give MHIP or the Plan Administrator any facts or consents (that may be required by a third party) it needs to apply these rules and determine benefits payable.

### ***Facility of Payment***

A payment made under another health plan may include an amount that should have been paid under this Plan. If it does, the Plan Administrator may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this Plan. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

### ***Right of Recovery***

Under the COB provision, MHIP has a right to recover any overpayments made for these services from the Member or Provider. The "amount of payments made" includes the reasonable cash value of any benefits provided in the form of services.

## **P. Third Party Liability/Subrogation**

The Plan will pay claims, subject to all terms and condition of the Plan, for medical expenses to treat injury or illness incurred by a Member as a result of the negligence, or other act, of a third party. If such Member is, or becomes, entitled to recover damages, or any other payment, as a result of the act of a third party, the Plan shall have a right of subrogation. The Plan shall have a first lien against any amount recovered up to the full amount actually paid by the Plan for claims incurred as a result of an act of a third party. The Plan's right to recover pursuant to this provision is not limited by the manner in which all or any portion of a sum recovered from a third party is characterized. The Plan has the right to assert such lien at any time. The Plan also has the right to institute a claim or lawsuit in the Member's name to pursue recovery. Members agree to cooperate fully with Plan efforts to pursue its rights as set forth in this paragraph. Such cooperation may include executing a written instrument. Members shall take no action prejudicing the rights and interests of the Plan under this provision. Costs incurred pursuing recovery, including attorney fees, are excluded from any amount subject to this right of subrogation.

**NOTE:** This provision does not apply to any benefits received by a Member under a Personal Injury Protection Policy (or "PIP"). PIP is insurance coverage without regard to fault provided under a Member's motor vehicle insurance policy.

## Section Three - Covered Services

This section explains the Deductibles, Out-of-Pocket Maximums, Prescription Drug Annual Maximum, and Lifetime Maximums applicable under the Plan's Benefit Options. This section also includes a Schedule of Benefits that outlines the Covered Services and the amount you pay for those services under each Benefit Option. It also includes information about the Plan's Prescription Drug program as well as detailed information about the Mental Health and Substance Abuse benefits available under the Plan.

**NOTE:** You are urged to carefully read this entire Certificate to identify the Health Care Services that are Covered Services and to determine what, if any, limitations or requirements exist for those Covered Services under the Benefit Option you have selected. Section Four of this Certificate contains important information about services or other items that are excluded from coverage. You are responsible for paying the designated Copayment or Deductible and Coinsurance as shown on the Schedule of Benefits in this section.

### A. Plan Year Deductibles, Out-of-Pocket Maximums, Prescription Drug Annual Maximum and Lifetime Maximum

#### ***Plan Year Deductibles***

##### ***How It Works***

Under the HealthyBlue Benefit Option, you must meet a Deductible for medical and/or Prescription Drug services each Plan Year of July 1 through June 30th before the Plan pays for Covered Services. Each Deductible is a designated annual fixed-dollar amount that you must pay for medical and/or Prescription Drug Covered Services before the Plan begins to pay. If you are a new Member who joined the Plan part way through the Plan Year, you have the remainder of the Plan Year to satisfy the applicable Deductible. If you are an existing Member, you have the full Plan Year to satisfy the applicable Deductible. Under certain circumstances, both new and existing Members may be eligible for a Deductible Carryover in the following Plan Year for a portion of their prior year Deductible expenses. (See Deductible Carryover discussion below). Once you meet your medical or Prescription Drug Deductible, you must pay any applicable Copayment or Coinsurance for medical or Prescription Drug Covered Services and no additional Deductible payments are required for the remainder of the Plan Year.

##### ***HMO Benefit Option (Prescription Drug Deductible Only)***

Members of the HMO Benefit Option must meet a Prescription Drug Deductible only:

<b>HMO Benefit Option Prescription Drug Deductible</b>
\$250 per Member with a \$500 family maximum

The following costs or payments do not contribute to the Prescription Drug Deductible:

- Costs incurred for non-Covered Services listed in Section Four, Exclusions and Limitations in this Certificate; and
- The difference in price between a Brand Name Drug and a Generic Drug if you request coverage of a Brand Name Drug when a generic is available.

Once you have satisfied the Prescription Drug Deductible, your applicable Copayments for Prescription Drugs will apply.

## Section Three - Covered Services

### HealthyBlue Benefit Option Deductibles

Under the HealthyBlue Benefit Option, separate Plan Year Deductibles apply to each Option:

HealthyBlue Benefit Option Deductibles		
Option 1 – In-Network	Option 2 – In-Network	Option 3 – Out-of-Network
The Individual Plan Year Deductible is \$1,500.	The Individual Plan Year Deductible is \$2,000.	The Individual Plan Year Deductible is \$2,500.
The Family Plan Year Deductible is \$3,000.*	The Family Plan Year Deductible is \$4,000.*	The Family Plan Year Deductible is \$5,000.*
<p>*For purposes of determining the Deductible, any Type of Coverage that is not Subscriber Only (i.e., Subscriber and Spouse, Subscriber and Child(ren), or Subscriber and Family) is considered Family coverage.</p> <p><b>Subscriber Only Coverage:</b> The Member must satisfy the Individual Deductible.</p> <p><b>Family Coverage:</b> Under any Type of Coverage other than Subscriber Only coverage, the Deductible can be met entirely by one Member or by combining eligible expenses of two or more covered family Members. <b>There is no Individual Deductible with Family Coverage.</b> The Family Deductible must be reached before CareFirst BlueChoice pays benefits for any Member under any Type of Coverage other than Subscriber Only coverage.</p>		
<p>The following amounts apply to each Deductible:</p> <ul style="list-style-type: none"> <li>• Copayments and Coinsurance for all Covered Services received under all options.</li> <li>• 100% of the Allowed Benefit for Covered Services rendered under all options that are subject to the Deductible as stated in the benefit chart below.</li> <li>• Copayments for Prescription Drug benefits.</li> </ul> <p>Member payments for Covered Services received throughout all options will contribute to the Option 1, Option 2 and Option 3 Deductibles.</p> <p>The Schedule of Benefits states whether a Covered Service is subject to the Plan Year Deductible and whether the Plan Year Deductible applies to Option 1, Option 2, Option 3 or all options.</p> <p>The following amounts may <u>not</u> be used to satisfy the Plan Year Deductible:</p> <ul style="list-style-type: none"> <li>• Amounts incurred for failure to comply with the Prior Authorization or Utilization Review requirements.</li> <li>• The portion of any provider charge that is in excess of the Allowed Benefit.</li> <li>• Charges for services which are not covered under this HMO Certificate of Coverage or which exceed the maximum number of covered visits/days listed below.</li> </ul>		

### Out-of-Pocket Maximums

The Plan has a Medical Benefit Out-of-Pocket Maximum and a Prescription Drug Out-of-Pocket Maximum for medical benefits and for Prescription Drug benefits as follows:

#### MEDICAL BENEFIT OUT-OF-POCKET MAXIMUM (HealthyBlue Benefit Option Only)

##### How It Works

The HealthyBlue Benefit Option has individual and family Plan Year Medical Benefit Out-of-Pocket Maximums. The annual Medical Benefit Out-of-Pocket Maximum is the most you will pay for your share of medical benefits during a single Plan Year. When this Maximum has been reached, no further Deductible, Coinsurance, or Copays will be required during the Plan Year for medical benefits, except

## Section Three - Covered Services

for Emergency Services Copays. Thereafter, the Plan will pay 100% of Covered Services for medical benefits according to the Plan's Allowed Benefits for services provided by both in-network and out-of-network Providers for the remainder of that Plan Year.

**NOTE:** The HMO Benefit Option has no Medical Benefit Out-of-Pocket Maximum. The HMO Benefit Option has a Prescription Drug Out-of-Pocket Maximum (see below).

### HMO Benefit Option

The HMO Benefit Option has a per Member Prescription Drug Out-of-Pocket Maximum. The annual Out-of-Pocket Maximum is the most a Member will pay for his or her share of Prescription Drug benefits under the Plan's Prescription Drug program during a single Plan Year. See Section Three, Part C – Prescription Drug Program. When the Member has reached this Out-of-Pocket Maximum, no further Deductible, Coinsurance, or Copays will be required for Prescription Drugs dispensed under the Plan's Prescription Drug program during the Plan Year. Thereafter, the Plan will pay 100% according to the Plan's Allowed Benefits for Prescription Drugs for the remainder of that Plan Year.

HMO Benefit Option Prescription Drug Out-of-Pocket Maximum
\$2,000

Each Member can satisfy his/her own annual Prescription Drug Out-of-Pocket Maximum. Each family Member must separately meet this per Member Prescription Drug Out-of-Pocket Maximum and the Member's Prescription Drug Out-of-Pocket Maximum cannot be reduced by eligible expenses for Prescription Drugs incurred by any other family Member. Once the Prescription Drug Out-of-Pocket Maximum has been met, Prescription Drug benefits will be paid in full for that Member.

The following amounts do not count towards the annual Prescription Drug Out-of-Pocket Maximum for the HMO Benefit Option:

- Deductibles, Coinsurance and Copays paid for Covered Services other than covered Prescription Drugs dispensed under the Plan's Prescription Drug program.
- Deductibles, Coinsurance and Copays paid for Prescription Drugs that are administered or dispensed by a Health Care Facility for a Member who is a patient in the Health Care Facility. This does not apply to Prescription Drugs that are dispensed by a pharmacy on the Health Care Facility's premises for a Member who is not a patient in the Health Care Facility.
- The portion of any charges for a covered Prescription Drug that is in excess of the Allowed Benefit.
- The difference in price between the Brand Name Drug and the generic equivalent when the Member requests a Brand Name Drug that has a generic equivalent.
- Amounts incurred for Prescription Drugs not covered under this HMO Certificate of Coverage.

### HealthyBlue Benefit Option

Members of the HealthyBlue Benefit Option have a combined Medical Benefit and Prescription Drug Out-of-Pocket Maximum.

HealthyBlue Benefit Option Out-Of-Pocket Maximums		
Option 1 – In-Network	Option 2 – In-Network	Option 3 – Out-of-Network
The Individual Plan Year Out-of-Pocket Maximum is \$4,500.	The Individual Plan Year Out-of-Pocket Maximum is \$6,000.	The Individual Plan Year Out-of-Pocket Maximum is \$7,500.
The Family Plan Year Out-of-Pocket Maximum is \$9,000.*	The Family Plan Year Out-of-Pocket Maximum is \$12,000.*	The Family Plan Year Out-of-Pocket Maximum is \$15,000.*
*For purposes of determining the out-of-Pocket Maximum, any Type of Coverage that is not Subscriber Only (i.e., Subscriber and Spouse, Subscriber and Child(ren), or Subscriber and Family) is considered Family coverage.		
<p><b>Subscriber Only Coverage:</b> The Subscriber must meet the Individual Out-of-Pocket Maximum.</p> <p><b>Family Coverage:</b> Under any Type of Coverage other than Subscriber Only coverage, the Out-of-Pocket Maximum can be met entirely by one Member or by combining eligible expenses of two or more Members.</p> <p><b>There is no Individual Out-of-Pocket Maximum with Family Coverage.</b> The Family Out-of-Pocket</p>		

## Section Three - Covered Services

Maximum must be reached before CareFirst BlueChoice waives payment of the listed amounts applying to the Out-of-Pocket Maximum.

These amounts apply to the Option 1, Option 2 and Option 3 Plan Year Out-of-Pocket Maximums:

- Copayments for all Covered Services received under all options.
- Copayments for Prescription Drug benefits.
- The Option 1, Option 2, and Option 3 Deductibles.

Member payments for Covered Services received throughout all options will contribute to the Option 1, Option 2 and Option 3 Plan Year Out-of-Pocket Maximum, including Prescription Drugs.

When the Member has reached the Out-of-Pocket Maximum under any option, no further Copayments, Coinsurance or Deductible will be required in that Plan Year under that option for Covered Services.

The following amounts may not be used to satisfy the Benefit Period Out-of-Pocket Maximum:

- Amounts incurred for failure to comply with the Prior Authorization or Utilization Review requirements.  
The portion of any provider charge that is in excess of the Allowed Benefit.
- Charges for services which are not covered under this HMO Certificate of Coverage or which exceed the maximum number of covered visits/days listed below.

### ***Prescription Drug Annual Maximum for Each Member***

The Prescription Drug Annual Maximum is the maximum dollar amount of Prescription Drug Covered Services payable by the Plan towards each Member's claims during a Plan Year.

	<b>HMO Benefit Option</b>	<b>HealthyBlue Benefit Option</b>
Prescription Drug Annual Maximum (per Member)	\$100,000	\$100,000

### ***Lifetime Maximum for Each Member***

The Lifetime Maximum is the maximum dollar amount of combined medical and Prescription Drug Covered Services payable by the Plan towards each Member's claims during the Member's lifetime.

	<b>HMO</b>	<b>HealthyBlue</b>
Lifetime Maximum (per Member)	\$2,000,000	\$2,000,000

## Section Three - Covered Services

### B. Schedule of Benefits

#### **Allergy Services**

Allergy Services	HMO	HealthyBlue		
		Option 1	Option 2	Option 3
Provider Office Visits	\$25 Copay (Primary Care Provider) \$35 Copay (Specialist)	No Copay (PCP)  \$20 per visit (Specialist)	Covered under Option 1 (PCP)  Option 2 Deductible, then \$20 per visit (Specialist)	Option 3 Deductible, then \$20 per visit
Allergy Testing	\$25 Copay (Primary Care Provider) \$35 Copay (Specialist)	No Copay (PCP)  \$20 per visit (Specialist)	Covered under Option 1 (PCP)  Option 2 Deductible, then \$20 per visit (Specialist)	Option 3 Deductible, then \$20 per visit
Allergy Injections	No Copay	No Copay (PCP)  \$20 per visit (Specialist)	Covered under Option 1 (PCP)  Option 2 Deductible, then \$20 per visit (Specialist)	Option 3 Deductible, then \$20 per visit

#### **Ambulance Transport (Non-Emergency)**

Prior Authorization may be required for non-emergency ambulance transport. No Prior Authorization is required for emergency ambulance transport or for facility-to-facility transport. See Section Two, Part H - Covered Services Requiring Prior Authorization.

Ambulance Transport (Non-Emergency)	HMO	HealthyBlue		
		Option 1	Option 2	Option 3
Ground and Air Ambulance Transport	No Copay	\$50 per service	\$50 per service	\$50 per service

#### **Blood & Blood Products**

All cost recovery expenses for Blood, Blood Products, derivatives, components, biologics, and serums to include autologous services, whole blood, red blood cells, platelets, plasma, immunoglobulin, and albumin are covered.

## Section Three - Covered Services

Blood and Blood Products	HMO	HealthyBlue		
		Option 1	Option 2	Option 3
Blood and Blood Products	No Copay	\$20 per visit	Option 2 Deductible, then \$100 per visit	Option 3 Deductible, then \$150 per visit

### Chemotherapy/Radiation Therapy

Chemotherapy/Radiation Therapy	HMO	HealthyBlue		
		Option 1	Option 2	Option 3
Provider Office Visits	\$25 Copay (Primary Care Provider) \$35 Copay (Specialist)	No Copay (PCP) \$20 per visit (Specialist)	Covered under Option 1 (PCP)  Option 2 Deductible, then \$20 per visit (Specialist)	Option 3 Deductible, then \$20 per visit
Inpatient Hospital (Prior Authorization required)	\$250 Copay per admission	Option 1 Deductible, then \$300 per day up to 5 days	Option 2 Deductible, then \$500 per day up to 5 days	Option 3 Deductible, then \$700 per day up to 5 days

### Controlled Clinical Trials

Prior Authorization is required. See Section Two, Part H - Covered Services Requiring Prior Authorization.

Controlled Clinical Trials	HMO	HealthyBlue		
		Option 1	Option 2	Option 3
Provider Office Visits	\$25 Copay (Primary Care Provider) \$35 Copay (Specialist)	No Copay (PCP) \$20 per visit (Specialist)	Covered under Option 1 (PCP)  Option 2 Deductible, then \$20 per visit (Specialist)	Option 3 Deductible, then \$20 per visit
Inpatient Hospital (Prior Authorization required)	\$250 Copay per admission	Option 1 Deductible, then \$300 per day up to 5 days	Option 2 Deductible, then \$500 per day up to 5 days	Option 3 Deductible, then \$700 per day up to 5 days
Outpatient Surgery Facility Services (Prior Authorization may be required)	No Facility Copay	Option 1 Deductible, then \$20 per visit	Option 2 Deductible, then \$100 per visit	Option 3 Deductible, then \$150 per visit

### Cosmetic and Reconstructive Surgery

## Section Three - Covered Services

**Prior Authorization may be required. See Section Two, Part H - Covered Services Requiring Prior Authorization.**

- Cosmetic and Related Reconstructive surgery is limited to the restoration of bodily function or correction of deformity resulting from disease, trauma, or congenital deformity including cleft lip or cleft palate or both.
- Surgical services are covered for a Medically Necessary mastectomy; reconstruction of the breast on which the mastectomy has been performed; and surgery and reconstruction of the other breast to produce a symmetrical effect regardless of the Member's insurance status at time of the mastectomy or the time lag between the mastectomy and reconstruction.
- Prostheses and services related to physical complication for all stages of mastectomy, including lymphedema are covered.

Covered Cosmetic and Reconstructive Services	HMO	HealthyBlue		
		Option 1	Option 2	Option 3
Provider Office Visits	\$25 Copay (Primary Care Provider) \$35 Copay (Specialist)	No Copay (PCP)  \$20 per visit (Specialist)	Covered under Option 1 (PCP)  Option 2 Deductible, then \$20 per visit (Specialist)	Option 3 Deductible, then \$20 per visit
Inpatient Hospital (Prior Authorization required)	\$250 Copay per admission	Option 1 Deductible, then \$300 per day up to 5 days, then no charge	Option 2 Deductible, then \$500 per day up to 5 days, then no charge	Option 3 Deductible, then \$700 per day up to 5 days, then no charge
Outpatient Surgery Facility Services (Prior Authorization may be required)	No Facility Copay	Option 1 Deductible, then \$20 per visit	Option 2 Deductible, then \$100 per visit	Option 3 Deductible, then \$150 per visit

### ***Dental Trauma***

**Prior Authorization may be required. See Section Two, Part H - Covered Services Requiring Prior Authorization.**

Covered Services include:

Dental trauma services performed in conjunction with treatment to teeth, gums, or a fractured jaw, but only when:

- The services are necessitated as a direct result of a Accidental Injury that occurred within the last six (6) months; and
- The Accidental Injury is not caused by biting or chewing.
- In reference to injury to a tooth, benefit coverage is limited to the repair of sound and natural teeth to their pre-injury level.

Operations on or for treatment of or to the teeth or supporting tissues of the teeth, but only when the services are for the removal of tumors or cysts.

## Section Three - Covered Services

General anesthesia and associated Hospital or ambulatory facility charges in conjunction with dental care provided to the following:

- Children who are 7 years old or younger or developmentally disabled and for whom a:
  - ▶ Successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual, or other medically compromising condition of the Member, and
  - ▶ Superior result can be expected from dental care provided under general anesthesia.
- Children who are 17 years old or younger who:
  - ▶ Are extremely uncooperative, fearful, or uncommunicative,
  - ▶ Have dental needs of such magnitude that treatment should not be delayed or deferred, and
  - ▶ Are Members for whom lack of treatment can be expected to result in oral pain, infection, loss of teeth, or other increased oral or dental morbidity.

Dental Trauma Service for Injury to Sound and Natural Teeth or for the Removal of Tumors or Cysts, including general anesthesia for certain children	HMO	HealthyBlue		
		Option 1	Option 2	Option 3
Provider Office Visits	\$25 Copay (Primary Care Provider) \$35 Copay (Specialist)	No Copay (PCP) \$20 per visit (Specialist)	Covered under Option 1 (PCP) Option 2 Deductible, then \$20 per visit (Specialist)	Option 3 Deductible, then \$20 per visit
Inpatient Hospital (Prior Authorization required)	\$250 Copay per admission	Option 1 Deductible, then \$300 per day up to 5 days, then no charge	Option 2 Deductible, then \$500 per day up to 5 days, then no charge	Option 3 Deductible, then \$700 per day up to 5 days, then no charge
Outpatient Surgery Facility Services (Prior Authorization may be required)	No Facility Copay	Option 1 Deductible, then \$20 per visit	Option 2 Deductible, then \$100 per visit	Option 3 Deductible, then \$150 per visit

### ***Diabetic Equipment and Services***

Coverage will be provided for Medically Necessary diabetes treatment, equipment, supplies; and Outpatient self-management training and educational services (including medical nutritional counseling at a CareFirst approved facility).

- Diabetes treatment, equipment and supplies
- Podiatric (foot) appliances for prevention of complications associated with diabetes (in accordance with Medicare guidelines); and
- Diabetes education services.

## Section Three - Covered Services

Diabetic Equipment and Services	HMO	HealthyBlue		
		Option 1	Option 2	Option 3
Provider Office Visits	\$25 Copay (Primary Care Provider) \$35 Copay (Specialist)	No Copay (PCP)  \$20 per visit (Specialist)	Covered under Option 1 (PCP)  Option 2 Deductible, then \$20 per visit (Specialist)	Option 3 Deductible, then \$20 per visit
Eye Care <i>Dilated eye exam (1 per Plan Year for diabetic Members)</i>	\$25 Copay (Primary Care Provider) \$35 Copay (Specialist)	No Copay (PCP)  \$20 per visit (Specialist)	Covered under Option 1 (PCP)  \$20 per visit (Specialist)	Deductible, then \$20 per visit
Patient Education	\$25 Copay per series of sessions	No Copay (PCP)  \$20 per visit (Specialist)	Covered under Option 1 (PCP)  Option 2 Deductible, then \$20 per visit (Specialist)	Option 3 Deductible, then \$20 per visit
Podiatrist	\$25 Copay (Primary Care Provider) \$35 Copay (Specialist)	No Copay (PCP)  \$20 per visit (Specialist)	Covered under Option 1 (PCP)  Option 2 Deductible, then \$20 per visit (Specialist)	Option 3 Deductible, then \$20 per visit
Prescription Drugs and Insulin	See the Prescription Drug Benefit	See the Prescription Drug Benefit	See the Prescription Drug Benefit	See the Prescription Drug Benefit
Diabetic Supplies	No Copay	No Copay	Covered under Option 1	No Copay

### ***Dialysis: Hospital-based, Outpatient Dialysis Center, or Home Dialysis***

Covered Services include Medically Necessary dialysis treatment, hemodialysis, or peritoneal dialysis for chronic kidney conditions at an Outpatient dialysis center and training in the operation of dialysis equipment, including supplies for and maintenance of dialysis equipment, used in a Member's home. Hospital-based dialysis services provided on an Inpatient basis requires Prior Authorization from the Plan. See "Hospital Inpatient Services" in this Section. **NOTE:** HMO Benefit Option Members cannot use an Outpatient dialysis facility that is a Non-Contracting Provider without Prior Authorization for the Plan.

## Section Three - Covered Services

	HMO	HealthyBlue		
		Option 1	Option 2	Option 3
Outpatient Dialysis Services or Home Dialysis	No Copay	\$20 per visit	Option 2 Deductible, then \$100 per visit	Option 3 Deductible, then \$150 per visit

### ***Durable Medical Equipment and Disposable Medical Supplies (DME/DMS)***

**Prior Authorization may be required. See Section Two, Part H - Covered Services Requiring Prior Authorization.**

To be covered, Durable Medical Equipment and Disposable Medical Supplies must be Medically Necessary.

DME/DMS include, but are not limited to, the following:

- Nebulizers, peak flow meters, crutches, walkers, oxygen, and equipment for the administration of oxygen, standard manual wheelchairs, and manual hospital beds;
- Medically Necessary medical foods and low protein modified food products for the therapeutic treatment, under the direction of a physician, of metabolic diseases and inborn deficiencies of amino acid metabolism. A low protein modified food product means a food product that is specially formulated to have less than 1 gram of protein per serving (excluding a natural food that is naturally low in protein).
- Ostomy and catheter supplies.
- Medically Necessary supplies required to operate DME;
- Sterile surgical supplies required immediately after surgery;
- Medically Necessary supplies needed to operate or use covered DME or Prosthetics or Orthotics; and
- Supplies needed for use by skilled home health or home infusion personnel, but only during the course of their required services.
- Insulin pumps and associated supplies

DME/DMS does not include convenience items, including, but not limited to, the following:

- Air Conditioners
- Air Cleaners
- Humidifiers
- Water Purifiers
- Physical Fitness Equipment
- Bathtub Lifts
- Bathtub Seats
- Carafes
- Elevators
- Emesis Basins
- Over bed Tables
- Raised Toilet Seats
- Standing Tables

For mastectomy-related supplies, see the **Cosmetic and Reconstructive Surgery** benefit.

Rental DME items may not become the property of the Member and must be returned to the DME Provider when no longer needed or upon termination of the Member's coverage, whichever occurs first. If the equipment is not returned by the Member or is returned in poor condition, the Member may be responsible for the replacement or repair cost.

Diabetic supplies (e.g., insulin syringes, test strips) are covered under the Prescription Drug program.  
MHIP/HMO-HB/COC (7/11)

## Section Three - Covered Services

Durable and Non-Durable Supplies	HMO	HealthyBlue		
		Option 1	Option 2	Option 3
Durable Medical Equipment	No Copay	Option 1 Deductible, then \$20 per device/supply	Option 2 Deductible, then \$100 per device/supply	Option 3 Deductible, then \$150 per device/supply
Disposable Medical Supplies	No Copay	Option 1 Deductible, then \$20 per device/supply	Option 2 Deductible, then \$100 per device/supply	Option 3 Deductible, then \$150 per device/supply

### **Emergency Services and Urgent Care**

You and/or a family Member, if capable, must contact Member Services at (866) 780-7105, within 48 hours of seeking Emergency Services that result in an Inpatient Hospital admission.

Urgent Care Services are provided at an Urgent Care center or facility for the relief of acute pain, initial treatment of acute infection, or a medical condition that requires medical attention, and a brief time lapse before care is obtained does not endanger life or permanent health.

Urgent Care conditions include, but are not limited to, minor sprains, fractures, pain, heat exhaustion, and breathing difficulties (other than those of sudden onset and persistent severity).

**See Section Two, Part I- Emergency Services and Part J- Urgent Care.**

Emergency Services	HMO	HealthyBlue		
		Option 1	Option 2	Option 3
Care for a Medical Emergency Provided in a Hospital Emergency room (ER) (with no admission to Hospital)	\$75 Copay	\$100 per visit	Covered under Option 1	
Care for a Medical Emergency Provided in a Hospital Emergency room (ER) (with admission to Hospital)	No Copay <i>(However, the \$250 per admission Hospital Inpatient Services Copay will apply)</i>	No Copay <i>(However, the Option 1 Deductible and Hospital Inpatient Services Copay will apply upon admission)</i>	Covered under Option 1	
Urgent Care	HMO	HealthyBlue		
Urgent Care Center/Facility	\$35 Copay per visit	Option 1	Option 2	Option 3
		\$50 per visit	Covered under Option 1	

## Section Three - Covered Services

### Family Planning Services

The following Medically Necessary services are covered:

- Counseling;
- Insertion or removal of contraceptive devices and examination associated with the use of contraceptive drugs or devices;
- Voluntary sterilization; and
- Coverage for oral contraceptives (see the Prescription Drugs section of this Schedule of Benefits)

Family Planning Services	HMO	HealthyBlue		
		Option 1	Option 2	Option 3
Provider Office Visits	\$25 Copay (Primary Care Provider) \$35 Copay (Specialist)	No Copay (PCP)  \$20 per visit (Specialist)	Covered under Option 1 (PCP)  Option 2 Deductible, then \$20 per visit (Specialist)	Option 3 Deductible, then \$20 per visit
Sterilization: Inpatient Hospital (Prior Authorization required)	\$250 Copay per admission	Option 1 Deductible, then \$300 per day up to 5 days	Option 2 Deductible, then \$500 per day up to 5 days	Option 3 Deductible, then \$700 per day up to 5 days
Sterilization: Outpatient Surgery Facility Services (Prior Authorization may be required)	No Facility Copay	Option 1 Deductible, then \$20 per visit	Option 2 Deductible, then \$100 per visit	Option 3 Deductible, then \$150 per visit
Sterilization: Provider Office	\$25 Copay (Primary Care Provider) \$35 Copay (Specialist)	No Copay (PCP)  \$20 per visit (Specialist)	Covered under Option 1 (PCP)  Option 2 Deductible, then \$20 per visit (Specialist)	Option 3 Deductible, then \$20 per visit

### Habilitative Care

Habilitative Care is covered for children between 0 and 19 years of age with a congenital or genetic birth defect and includes services for orthodontics, oral surgery, otologic, audiologic, and speech therapy, physical therapy, and occupational therapy to enhance the Member's ability to function. Congenital or genetic birth defects include, but are not limited to: autism or an autism spectrum disorder, and cerebral palsy. Benefits are not available for Habilitative Services delivered through early intervention and school services.

## Section Three - Covered Services

Habilitative Services	HMO	HealthyBlue		
		Option 1	Option 2	Option 3
Provider Office Visits	\$25 Copay (Primary Care Provider) \$35 Copay (Specialist)	No Copay (PCP)  \$20 per visit (Specialist)	Covered under Option 1 (PCP)  Option 2 Deductible, then \$20 per visit (Specialist)	Option 3 Deductible, then \$20 per visit
Inpatient Hospital (Prior Authorization required)	\$250 Copay per admission	Option 1 Deductible, then \$300 per day up to 5 days	Option 2 Deductible, then \$500 per day up to 5 days	Option 3 Deductible, then \$700 per day up to 5 days
Physical, speech, or occupational therapy (30 visits per diagnosis per Plan Year)	\$25 Copay (Primary Care Provider) \$35 Copay (Specialist)	\$20 per visit	Option 2 Deductible, then \$20 per visit	Option 3 Deductible, then \$20 per visit
		<i>Note: Benefits obtained under Option 1, Option 2 or Option 3 count against 30 visit limitation on physical, speech or occupational</i>		

### Hearing Aids for Minor Children

Benefits for a hearing aid are provided for a Member who is a minor child, when the hearing aid is prescribed, fitted and dispensed by a licensed audiologist. The Plan will cover up to the maximum payment as stated below every thirty-six (36) months for one hearing aid for each hearing-impaired ear.

Hearing Aids for Minor Children	HMO	HealthyBlue		
		Option 1	Option 2	Option 3
Hearing Aids per Hearing Impaired Ear (Maximum of \$1,400 per ear every 36 months ONLY for Children through 18 years of age)	No Copay	\$20 per hearing aid	Option 2 Deductible, then \$100 per hearing aid	Option 3 Deductible, then \$150 per hearing aid
Related Professional Services	\$25 Copay (Primary Care Provider) \$35 Copay (Specialist)	\$20 per visit	Option 2 Deductible, then \$100 per visit	Option 3 Deductible, then \$150 per visit

### Home Health Care

**Prior Authorization is required. See Section Two, Part H - Covered Services Requiring Prior Authorization.**

Benefits for Home Health Care are covered for Members

- As an alternative to otherwise Covered Services in a Hospital or related institution; or
- Who receive less than 48 hours of Inpatient hospitalization following a mastectomy or removal

## Section Three - Covered Services

of a testicle or who undergo a mastectomy or removal of a testicle on an Outpatient basis. Benefits provided include:

- ▶ One home visit scheduled to occur within 24 hours after discharge from the Hospital or Outpatient Health Care Facility, and
- ▶ An additional home visit if prescribed by the attending physician.

Home Health Care	HMO	HealthyBlue		
		Option 1	Option 2	Option 3
Home Health Care after Mastectomy or Surgical Removal of a Testicle	No Copay	No Copay	No Copay	No Copay
All other Home Health Care	No Copay	Option 1 Deductible, then \$20 per visit	Option 2 Deductible, then \$100 per visit	Option 3 Deductible, then \$150 per visit

### **Hospice Care**

**Prior Authorization is required. See Section Two, Part H - Covered Services Requiring Prior Authorization.**

Hospice	HMO	HealthyBlue		
		Option 1	Option 2	Option 3
Inpatient Hospice Services	No Copay	Option 1 Deductible, then \$20 per day	Option 2 Deductible, then \$100 per day	Option 3 Deductible, then \$150 per day
Outpatient Hospice Services	No Copay	Option 1 Deductible, then \$20 per day	Option 2 Deductible, then \$100 per day	Option 3 Deductible, then \$150 per day

## Section Three - Covered Services

### ***Hospital Inpatient Services***

**Prior Authorization is required. See Section Two, Part H - Covered Services Requiring Prior Authorization.**

The following Hospital facility services are covered with Prior Authorization:

- Medically Necessary Hospital services; and
- Semiprivate room and board (unless only private rooms are available or a private room is Medically Necessary).

Inpatient Hospital Services	HMO	HealthyBlue		
		Option 1	Option 2	Option 3
<p>Inpatient Hospital Services</p> <p>Prior Authorization is not required for emergency admissions.</p> <p><b>For HealthyBlue Benefit Option Only:</b> Hospitalization solely for Rehabilitation limited to 90 days per option per Benefit Period</p> <p>Member is responsible for obtaining authorization for services rendered outside of Service Area by Out-of-Network Participating Providers and services by Out-of-Network Non-Participating Providers.</p>	\$250 Copay per admission	Option 1 Deductible, then \$300 per day up to 5 days, then no charge	Option 2 Deductible, then \$500 per day up to 5 days, then no charge	Option3 Deductible, then \$700 per day up to 5 days, then no charge

### ***Infertility Testing and Diagnosis***

**Prior Authorization is required. See Section Two, Part H - Covered Services Requiring Prior Authorization.**

Services provided on an Outpatient basis to determine the **cause** of infertility include, but are not limited to:

- Consultation with a reproductive endocrinology/infertility Specialist;
- Complete semen analysis;
- Midluteal endometrial biopsy;
- Hysterosalpingogram, as an initial test of tubal patency, unless contraindicated;
- A post-coital exam;
- Medically Necessary laboratory testing to determine cause of infertility;
- A diagnostic laparoscopy with chromotubulation; and
- A hysteroscopy if the hysteroqram is not normal.

**NOTE: The Plan does not cover** artificial insemination and infertility treatment, including, but not limited to, in vitro fertilization, ovum transplants and gamete intrafallopian tube transfer, zygote intrafallopian transfer, cryogenic or other preservation techniques used in these or similar procedures, or the drugs used in support of any of the above mentioned artificial insemination or infertility treatment.

## Section Three - Covered Services

Infertility Testing and Diagnosis Services	HMO	HealthyBlue		
		Option 1	Option 2	Option 3
Provider Office Visits	\$25 Copay (Primary Care Provider) \$35 Copay (Specialist)	No Copay (PCP)  \$20 per visit (Specialist)	Covered under Option 1 (PCP)  Option 2 Deductible, then \$20 per visit (Specialist)	Option 3 Deductible, then \$20 per visit
Outpatient Surgery Facility Services (Prior Authorization may be required)	No Facility Copay	Option 1 Deductible, then \$20 per visit	Option 2 Deductible, then \$100 per visit	Option 3 Deductible, then \$150 per visit

### Limited Service Immediate Care

Coverage is provided for treatment of common conditions or ailments, which require rapid and specific treatment that can be administered in a limited duration of time. Limited Service Immediate Care services are non-emergency and non-urgent services. Services are provided in Limited Service Immediate Care Centers, which are mini-medical office chains typically staffed by nurse practitioners with an on-call physician. Examples of common ailments for which a reasonable, prudent layperson who possesses an average knowledge of health and medicine would seek Limited Service Immediate Care, include but are not limited to: ear, bladder, and sinus infections; pink eye; flu; and strep throat.

Limited Service Immediate Care	HMO	HealthyBlue		
		Option 1	Option 2	Option 3
	\$35 Copay	\$20 per visit	Covered under Option 1	Option 3 Deductible, then \$20 per visit

### Maternity Care

Women are encouraged to contact Member Services at (443) 725-1010 or toll free at (888) 456-2024 as soon as possible once they know they are pregnant. This enables the Plan Administrator to work with the treating Provider to monitor for high-risk pregnancy factors and to assist a parent in completing steps to assure that Plan benefits will be available for the newborn child.

Maternity care is covered as any other medical condition. Coverage includes normal pregnancy and complications of pregnancy. Coverage also includes the following preventive services:

- Screening for asymptomatic bacteriuria;
- Behavioral interventions to promote breastfeeding;
- Screening for Hepatitis B virus infection; and
- Screening for iron deficiency anemia.

Limitations:

- Routine screening sonograms (OB ultrasounds) are covered only if Medically Necessary.
- Audiology screening for newborns limited to one screen and one confirming screen.
- Newborn infants are automatically covered for the first 31 days (from the date of birth). See Section One, Part D - Coverage Changes for details on enrolling your newborn infant.

## Section Three - Covered Services

Maternity Services	HMO	HealthyBlue		
		Option 1	Option 2	Option 3
Provider Office Visits during pregnancy	\$25 Copay (Initial visit only)	Option 1 Deductible, then \$20 per visit (Specialist)	Covered under Option 1	Option 3 Deductible, then \$20 per visit
Inpatient Hospital (No Prior Authorization required for routine maternity admissions)  <b>For HealthyBlue Benefit Option Only:</b> For non-routine maternity admissions, the Member is responsible for obtaining authorization for services rendered outside of Service Area by Out-of-Network Participating Providers and services by Out-of-Network Non-Participating Providers.	\$250 Copay per admission	Option 1 Deductible, then \$300 per day up to 5 days, then no charge	Covered under Option 1	Option 3 Deductible, then \$700 per day up to 5 days, then no charge
Abortion: Inpatient (prior authorization required)	\$250 Copay per admission	Option 1 Deductible, then \$300 per day up to 5 days	Option 2 Deductible, then \$500 per day up to 5 days	Option 3 Deductible, then \$700 per day up to 5 days
Abortion: Outpatient Surgery Facility Services (Prior Authorization may be required)	No Facility Copay	Option 1 Deductible, then \$20 per visit	Option 2 Deductible, then \$100 per visit	Option 3 Deductible, then \$150 per visit

**Please Note:** The Plan 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 an uncomplicated vaginal delivery, or less than 96 hours following an uncomplicated Cesarean section. However, if mother elects a shorter Hospital stay than provided above, the Plan will cover:

- One home visit scheduled to occur within 24 hours after Hospital discharge; and
- An additional home visit if prescribed by the attending Provider.

The Plan will also cover a home visit, if the attending Provider prescribes one for mother who has a Hospital length of stay more than 48 hours following an uncomplicated vaginal delivery, or more than 96 hours following an uncomplicated Cesarean section.

If mother is required to remain in the Hospital after childbirth (more than 48 hours following an uncomplicated vaginal delivery, or more than 96 hours following an uncomplicated Cesarean section), the Plan will cover up to an additional 4 days for the newborn.

## Section Three - Covered Services

### ***Mental Health and Substance Abuse Services***

Prior Authorization may be required. See Section Two, Part H - Covered Services Requiring Prior Authorization.

Mental Health and Substance Abuse Services for MHIP are administered by the Plan Administrator in cooperation with Magellan Health Services ("Magellan"). Magellan is an independent company.

**All Members** must call Magellan Health Services at (800) 245-7013 and obtain Prior Authorization prior to receiving **ALL** Outpatient, Intensive Outpatient (IOP), Partial Mental Health Hospitalization (PHP), or Inpatient Mental Health or Substance Abuse services. **Members enrolled in the HMO Benefit Option may only see Mental Health and Substance Abuse Providers in the Magellan Health Services Network.**

#### Emergency Services

**Whenever you have a crisis, call Magellan's toll-free number, (800) 245-7013, 24 hours a day 7 days a week.** For life threatening emergencies, it is always recommended that Members call 911 to access emergency services in your area.

Mental Health	HMO	HealthyBlue		
		Option 1	Option 2	Option 3
<p>Inpatient Psychiatric, Residential, or Treatment/Crisis Center <i>(Maximum of 60 days per Member per Plan Year, combined with Substance Abuse; 2 days of Partial Hospitalization equals 1 Inpatient hospitalization day)</i> (Prior Authorization required)</p> <p><b>For HealthyBlue Benefit Option Only:</b> Member is responsible for obtaining authorization for services rendered outside of Service Area by Out-of-Network Participating Providers and services by Out-of-Network Non-Participating Providers.</p>	\$250 Copay per admission	Option 1 Deductible, then \$300 per day up to 5 days, then no charge	Covered Under Option 1	Option 3 Deductible, then \$700 per day up to 5 days, then no charge
Inpatient Professional Services	No Copay	\$20 per visit	Covered under Option 1	\$150 per visit
Partial Hospitalization	\$250 Copay per admission	\$20 per visit	Covered under Option 1	\$150 per visit

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Mental Health	HMO	HealthyBlue		
		Option 1	Option 2	Option 3
Individual Psychiatric Sessions, Intensive Outpatient or Treatment Sessions Group Sessions provided at an Outpatient Hospital or Ambulatory Care Facility	30% of the Allowed Benefit	Option 1 Deductible, then \$20 per visit	Covered under Option 1	Option 3 Deductible, then \$20 per visit
Outpatient Services	30% of the Allowed Benefit	Option 1 Deductible, then \$20 per visit	Covered under Option 1	Option 3 Deductible, then \$20 per visit
Medication Management	\$25 Copay (Primary Care Provider) \$35 Copay (Specialist)	No Copay (PCP) \$20 per visit (Specialist)	Covered Under option 1	Option 3 Deductible, then Deductible, then \$20 per visit
Substance Abuse	HMO	HealthyBlue		
		Option 1	Option 2	Option 3
Inpatient Substance Abuse Rehabilitation ( <i>Maximum of 60 days per Member per Plan Year, combined with Mental Health; 2 days of Partial Hospitalization equals 1 Inpatient hospitalization day</i> ) (Prior Authorization required)  <b>For HealthyBlue Benefit Option Only:</b> Member is responsible for obtaining authorization for services rendered outside of Service Area by Out-of-Network Participating Providers and services by Out-of-Network Non-Participating Providers.	\$250 Copay per admission	Option 1 Deductible, then \$300 per day up to 5 days, then no charge	Covered Under Option 1	Option 3 Deductible, then \$700 per day up to 5 days, then no charge
Inpatient Professional Services	No Copay	\$20 per visit	Covered under Option 1	\$150 per visit
Partial Hospitalization	\$250 Copay per admission	\$20 per visit	Covered under Option 1	\$150 per visit

## Section Three - Covered Services

Mental Health	HMO	HealthyBlue		
		Option 1	Option 2	Option 3
Inpatient Substance Abuse Detoxification/Withdrawal ( <i>Not Limited</i> ) (Prior Authorization required)	\$250 Copay per admission	Option 1 Deductible, then \$300 per day up to 5 days, then no charge	Covered Under Option 1	Option 3 Deductible, then \$700 per day up to 5 days, then no charge
Individual Substance Abuse Sessions, Intensive Outpatient Treatment Sessions, Group Sessions, or Substance Abuse Intensive Outpatient Rehabilitation (IOP) provided at an Outpatient Hospital or Ambulatory Care Facility	30% of the Allowed Benefit	Option 1 Deductible, then \$20 per visit	Covered under Option 1	Option 3 Deductible, then \$20 per visit
Outpatient Services	30% of the Allowed Benefit (Prior Authorization required)	Option 1 Deductible, then \$20 per visit	Covered under Option 1	Option 3 Deductible, then \$20 per visit
Medication Management	\$25 Copay (Primary Care Provider) \$35 Copay (Specialist)	No Copay (PCP) \$20 per visit (Specialist)	Covered Under option 1	Option 3 Deductible, then Deductible, then \$20 per visit

### Oral Surgery

**Prior Authorization may be required. See Section Two, Part H - Covered Services Requiring Prior Authorization.**

- Benefits for oral surgery include:
  - ▶ Medically Necessary procedures, as determined by the Plan, to attain functional capacity, correct a congenital anomaly, reduce a dislocation, repair a fracture, excise tumors, cysts or exostoses, or drain abscesses with cellulitis and are performed lips, tongue, roof and floor of the mouth, accessory sinuses, salivary glands or ducts, and jaws.
  - ▶ Medically Necessary procedures, as determined by the Plan, needed as a result of an Accidental Injury, when the Member requests oral surgical services or dental services for sound natural teeth and supporting structures or the need for oral surgical services or dental services for sound natural teeth and supporting structures is identified in the patient's medical records within sixty (60) days of the accident. Benefits for such oral surgical services shall be provided up to three (3) years from the date of injury.
  - ▶ Medically Necessary oral surgical services for the treatment of cleft lip or cleft palate or both.
- All treatments or procedures for the treatment of Temporomandibular Joint Syndrome (TMJ) and the treatment for craniomandibular pain syndrome (CPS) are excluded, except for surgical services for TMJ and CPS, if Medically Necessary and if there is clearly demonstrable radiographic evidence of joint abnormality due to disease or injury.

## Section Three - Covered Services

- All other procedures involving the teeth or areas surrounding the teeth including the shortening of the mandible or maxillae for Cosmetic purposes or for correction of malocclusion unrelated to a functional impairment are excluded.

Oral Surgery	HMO	HealthyBlue		
		Option 1	Option 2	Option 3
Provider Office Visits	\$25 Copay (Primary Care Provider) \$35 Copay (Specialist)	No Copay (PCP)  \$20 per visit (Specialist)	Covered under Option 1 (PCP)  Option 2 Deductible, then \$20 per visit (Specialist)	Option 3 Deductible, then \$20 per visit
Inpatient Hospital (Prior Authorization required)	\$250 Copay per admission	Option 1 Deductible, then \$300 per day up to 5 days, then no charge	Option 2 Deductible, then \$500 per day up to 5 days	Option 3 Deductible, then \$700 per day up to 5 days, then no charge
Outpatient Surgery Facility Services (Prior Authorization may be required)	No Facility Copay	Option 1 Deductible, then \$20 per visit	Option 2 Deductible, then \$100 per visit	Option 3 Deductible, then \$150 per visit

### ***Organ and Tissue Transplants***

**Prior Authorization is required. See Section Two, Part H - Covered Services Requiring Prior Authorization.**

Transplant-related services must be provided at or arranged by a Transplant Facility designated and approved by the Plan. Members should contact Member Services at (443) 725-1010 or toll free at (888) 456-2024, for information on designated Transplant Facilities.

Hospital, surgical and medical services for the following human transplants are covered, provided they meet requirements for the specific transplant surgery:

- Autologous and non-autologous bone marrow transplants
- Cornea
- Heart
- Heart/Lung
- Kidney
- Liver
- Lung (single or double)
- Pancreas
- Pancreas/Kidney
- Small Bowel

Transplant services and supplies include the recipient's medical and surgical services in connection with the transplant including:

- Immunosuppressive medications;
- Organ and tissue search and procurement;
- Harvesting and storage of bone marrow; and
- Pre-transplant evaluation.

## Section Three - Covered Services

In order to be considered as Covered Services, the transplant and the transplant-related services and supplies must meet all of the following requirements:

- All Organ and Tissue Transplant services require Prior Authorization.
- All transplant-related services must be provided at or arranged by a Transplant Facility designated and approved by the Plan.
- The transplant must be Medically Necessary and appropriate for the Member's medical condition.
- The transplant must not be Experimental/Investigational or unproven for the Member's condition.

When both the recipient and the donor are Covered Individuals, each is entitled to the benefits of this Plan.

When only the recipient is a Covered Individual, both the donor and the recipient are entitled to the benefits of this Plan, but the donor benefits are limited to only those not available from any other source to which the donor may have access. Costs of benefits for the donor will be charged against the recipient's coverage under this Plan.

No expenses are payable for a Covered Individual who donates an organ or tissue, unless the person who receives the transplant is a Covered Individual under this Plan.

Organ and Tissue Transplants	HMO	HealthyBlue		
		Option 1	Option 2	Option 3
Provider Office Visits	\$25 Copay (Primary Care Provider) \$35 Copay (Specialist)	No Copay (PCP) \$20 per visit (Specialist)	Covered under Option 1 (PCP) Option 2 Deductible, then \$20 per visit (Specialist)	Option 3 Deductible, then \$20 per visit
Inpatient Hospital (Prior Authorization required)	\$250 Copay per admission	Option 1 Deductible, then \$300 per up to 5 days, then no charge	Option 2 Deductible, then \$500 per day up to 5 days, then no charge	Option 3 Deductible, then \$700 per day up to 5 days, then no charge

### Orthotics

Prior Authorization may be required. See Section Two, Part H- Covered Services Requiring Prior Authorization.

	HMO	HealthyBlue		
		Option 1	Option 2	Option 3
Orthotics	No Copay	Option 1 Deductible, then \$20 per device/supply	Option 2 Deductible, then \$100 per device/supply	Option 3 Deductible, then \$150 per device/supply

## Section Three - Covered Services

### Outpatient Services

Prior Authorization may be required. See Section Two, Part G - Covered Services Requiring Prior Authorization.

Outpatient services include, but are not limited to, diagnostic, radiological and laboratory services and Outpatient surgery facility services. See also Physician Services, below.

Outpatient Services	HMO	HealthyBlue		
		Option 1	Option 2	Option 3
Laboratory Services	\$25 Copay per visit	No Copay	Covered Under Option 1	No Copay
Radiology Services	\$25 Copay per visit	No Copay	Covered Under Option 1	No Copay
Outpatient Surgery Facility Services (Prior Authorization may be required)	No Facility Copay	Option 1 Deductible, then \$20 per visit	Option 2 Deductible, then \$100 per visit	Option 3 Deductible, then \$150 per visit

### Physician Services

Physician services include:

- Primary care and specialty Health Care Services rendered in an office setting;
- Health Care Services rendered in an Emergency Room or Urgent Care facility; and
- Professional fees for surgeon and necessary assistant surgeon associated with Medically Necessary surgical procedures.

Physician Services	PPO In-Network	PPO Out-of-Network	HDP In-Network	HDP Out-of-Network
Office Visits	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit
Professional fees associated with: <ul style="list-style-type: none"> <li>▪ Inpatient Hospitalization</li> </ul>	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit
Professional fees associated with: <ul style="list-style-type: none"> <li>▪ Outpatient Surgical Services</li> </ul>	20% of the Allowed Benefit	40% of the Allowed Benefit	20% of the Allowed Benefit	40% of the Allowed Benefit
Emergency Room or Urgent Care physician services when performed in a licensed ER or Urgent Care Facility*	20% of the Allowed Benefit		20% of the Allowed Benefit	

## Section Three - Covered Services

**\*NOTE:** Refer to the “Emergency Services and Urgent Care” description in this section for applicable facility services Copays.

### **Physician Services: Primary Care Medical Home**

See Section Two, Part E for a description of the Primary Care Medical Home program.

Primary Care Medical Home	HMO	HealthyBlue		
		Option 1	Option 2	Option 3
Associated Costs for the Primary Care Medical Home Program	No Copay or Coinsurance	No Copay or Coinsurance	Covered under Option 1	Not Covered

### **Prescription Drugs**

See Part C at the end of this Section Three for more information on the Prescription Drug program.

To be covered, Prescription Drugs must be approved by the U.S. Food and Drug Administration (FDA) as requiring a prescription, and prescribed by a physician or other Health Care Provider authorized by law to prescribe them. Covered Prescription Drugs are subject to Utilization Review by the Plan.

The following equipment and supplies are covered under the Prescription Drug benefit:

- Glucose monitoring equipment (glucometers), insulin syringes, needles, test strips for glucometers and medications for treatment of diabetes. Disposable diabetic supplies are covered at the Generic Drug Copay level when dispensed at a participating pharmacy.

The Copays listed below are only applicable if the cost of the Prescription Drug is more than the applicable Copay. If the cost of the prescription is less than the applicable Copay, you will pay the actual cost of the Prescription Drug.

**NOTE:** There is a separate Prescription Drug Out-of-Pocket Maximum for the HMO Benefit Option. (See Section Three, Part C).

**NOTE:** Prescription Drug benefits are subject to a \$100,000 Prescription Drug Annual Maximum per Member. (See Section Three, Part C).

Prescription Drugs	HMO	HealthyBlue
<b>Retail (31 day supply)</b>		
Preferred Preventive Drugs <b>(HealthyBlue Benefit Option Only)</b>	<i>Not Applicable</i>	No Copay
Generic Drug	Deductible, then \$15 Copay	Option 1 Deductible, then \$4 Copay
Preferred Brand Name Drug	Deductible, then \$35 Copay	Option 1 Deductible, then \$45 Copay
Non-Preferred Brand Name Drug	Deductible, then \$75 Copay	Option 1 Deductible, then \$65 Copay
Select Brand Name	Deductible, then \$125 Copay	Option 1 Deductible, then \$125

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Drugs		Copay
<b>Specialty Injectibles (Up to one month supply)</b>	<b>HMO</b>	<b>HealthyBlue</b>
Generic Drug	Deductible, then \$15 Copay	Option 1 Deductible, then \$4 Copay
Preferred Brand Name Drug	Deductible, then \$35 Copay	Option 1 Deductible, then \$45 Copay
Non-Preferred Brand Name Drug	Deductible, then \$75 Copay	Option 1 Deductible, then \$65 Copay
Select Brand Name Drugs	Deductible, then \$125 Copay	Option 1 Deductible, then \$125 Copay
<b>Maintenance Medications Retail or Mail Order (Up to a 90-day supply)</b>	<b>HMO</b>	<b>HealthyBlue</b>
Preferred Preventive Drugs (HealthyBlue Benefit Option Only)	<i>Not Applicable</i>	No Copay
Generic Drug	\$30 Copay	Option 1 Deductible, then \$8 Copay
Preferred Brand Name Drug	\$70 Copay	Option 1 Deductible, then \$90 Copay
Non-Preferred Brand Name Drug	\$150 Copay	Option 1 Deductible, then \$130 Copay
Select Brand Name Drugs	\$250 Copay	Option 1 Deductible, then \$250 Copay

**For the HealthyBlue Benefit Option**, the Preferred Preventive Drug tier means the list issued by CareFirst BlueChoice of certain preventive Prescription Drugs related to diabetes, high cholesterol, high blood pressure (hypertension), depression or asthma. Not all preventive Prescription Drugs are included on the Preferred Preventive Drug List. CareFirst BlueChoice may change this list periodically without notice to Members. A copy of the Preferred Preventive Drug List is available to the Member upon request.

If you request a Brand Name Drug when a lower-cost Generic Drug is available, you will be required to pay the difference in price between the two drugs, *plus* the applicable Preferred Brand Name Drug Copay.

**NOTE 1:** If you fill your prescription at a non-participating pharmacy, you must pay 100% of the drug cost at the time of purchase and submit a claim form for reimbursement. Reimbursement will be based

## Section Three - Covered Services

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*upon the network-contracted rate and must be for a medication that is on the preferred drug list without requiring Prior Authorization, or has been authorized by MHIP prior to date of fill and is within the quantity level limit allowed by the Plan.*

### **Preventive Services**

For Members of the HMO Benefit Option, the Plan will cover the preventive services listed below for a \$10 Copay (**except** as otherwise indicated) when the preventive services are provided by the Members' Primary Care Provider in connection with an annual physical exam or well child visit.

The Plan will cover the preventive services listed below for a \$10 Copayment, unless a different Copayment or Coinsurance is specified, when the preventive services are provided in-network in connection with an annual physical exam, well child visit, or a preventive screening.

Members in the HealthyBlue Benefit Option do not have to satisfy their Deductible before the in-network \$10 Copayment applies. **Preventive Services are not covered under Option 3 in the HealthyBlue Benefit Option..**

The Copayments listed below apply only to routine preventive screenings. Members, who have been previously diagnosed with a condition for which there is a preventive screening and need additional related services, are subject to the designated Copayment and Coinsurance as identified in the schedule of benefits within the Certificate of Coverage.

The Copayments listed below do not apply to:

- Screenings that are not provided in accordance with the time period limitations listed below or as part of an annual physical exam or well child visit as required below, but rather are provided in connection with the diagnosis of Members presenting symptoms of any disease, disorder, or condition; or
- Treatment of any disease, disorder, or condition diagnosed during a physical exam, well child visit, or preventive screening.

If during your annual physical exam, well child visit, or preventive screenings it is determined that subsequent treatment is necessary, those services would be subject to Copayments as identified in the schedule of benefits within the HMO Certificate of Coverage.

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Preventive Services	HMO	HealthyBlue		
		Option 1	Option 2	Option 3
Annual Physical Examination (including immunizations) <i>(1 per Plan Year)*</i>	\$10 Copay	No Copayment	Covered under Option 1	Not Covered
Adult Immunization(s) (given outside of an annual physical examination) <i>As recommended by Advisory Committee on Immunization Practices or US Preventative Services Task Force</i>	\$10 Copay	No Copayment	Covered under Option 1	Not Covered
Abdominal Aortic Aneurysm Screening <i>(One-time screening by ultrasonography of men aged 65 to 75 who have smoked)</i>	\$10 Copay	No Copayment	Covered under Option 1	Not Covered
Alcohol Misuse Screening <i>(Coverage limited to an initial screening provided by a Primary Care Provider in connection with an annual physical examination).</i>	\$10 Copay	No Copayment	Covered under Option 1	Not Covered
Behavioral Education in Primary Care to Promote a Healthy Diet <i>(For adults with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease)</i> <b>NOTE:</b> Coverage limited to behavioral education provided by a Primary Care Provider in connection with an annual physical examination.	\$10 Copay	No Copayment	Covered under Option 1	Not Covered
Breast Cancer Chemoprevention Screening <i>(To identify women at high risk of breast cancer and low risk for adverse effects of chemoprevention).</i>	\$10 Copay	No Copayment	Covered under Option 1	Not Covered
Cervical Cancer Screening (e.g. pap smear) <i>(1 per Plan Year)</i>	\$10 Copay	No Copayment	Covered under Option 1	Not Covered
Chlamydia Screening Test	\$10 Copay	No Copayment	Covered under Option 1	Not Covered
Colorectal Screening	\$10 Copay	No Copayment	Covered under	Not Covered

## Section Three - Covered Services

Preventive Services	HMO	HealthyBlue		
		Option 1	Option 2	Option 3
<p>(Men and Women age 40 years and older)</p> <ul style="list-style-type: none"> <li>▪ Digital rectal exam (1 per Plan Year)</li> </ul> <p>(Men and Women age 50 years and over)</p> <ul style="list-style-type: none"> <li>▪ Fecal occult blood test (1 per Plan Year)</li> <li>▪ Flexible Sigmoidoscopy every 5 years</li> <li>▪ Colonoscopy every 10 years</li> </ul> <p>Double contrast barium enema every 5 years</p>			Option 1	
<p>Depression Screening (Provided in connection with an annual physical examination by a Primary Care Provider only)</p>	\$10 Copay	No Copayment	Covered under Option 1	Not Covered
<p>Diabetes Mellitus (Type 2) Screening for Adults (For adults with hypertension or hyperlipidemia)</p>	\$10 Copay	No Copayment	Covered under Option 1	Not Covered
<p>Genetic Risk Assessment and BCRA Mutation testing for Breast and Ovarian Cancer Susceptibility (For women whose family history is associated with an increased risk for deleterious mutations in the BRCA1 or BRCA2 genes)</p>	\$10 Copay	No Copayment	Covered under Option 1	Not Covered
<p>Gonorrhea Screening (For sexually active women, including pregnant women 25 and younger, or those adults or adolescents at increased risk of infection)</p>	\$10 Copay	No Copayment	Covered under Option 1	Not Covered
<p>High Blood Pressure Screening</p>	\$10 Copay	No Copayment	Covered under Option 1	Not Covered
<p>HIV Screening (For all adolescents and adults at increased risk for HIV infection and all pregnant women)</p>	\$10 Copay	No Copayment	Covered under Option 1	Not Covered

## Section Three - Covered Services

Preventive Services	HMO	HealthyBlue		
		Option 1	Option 2	Option 3
Lipid Disorder (Cholesterol) Screening <i>(For men 35 and older, women 45 and older, and younger adults with other risk factors for coronary disease)</i>	\$10 Copay	No Copayment	Covered under Option 1	Not Covered
Mammogram Screening <i>(At intervals determined to be appropriate by your Health Care Provider.)</i>	\$10 Copay	No Copayment	Covered under Option 1	Not Covered
Obesity Screening in Adults <b>NOTE:</b> Coverage limited to screening provided by a Primary Care Provider in a primary care setting.	\$10 Copay	No Copayment	Covered under Option 1	Not Covered
Osteoporosis Screening <ul style="list-style-type: none"> <li>▪ Bone Mass Measurement</li> <li>2 per Plan Year without Prior Authorization for Men and Women age 40 and above</li> </ul>	\$10 Copay	No Copayment	Covered under Option 1	Not Covered
Prostate Cancer Screening <ul style="list-style-type: none"> <li>▪ Digital rectal exam for men <i>(1 per Plan Year for Men 40 and above)</i></li> <li>▪ PSA Screening for men <i>(1 per Plan Year)</i></li> </ul>	\$25 Copay (Primary Care Provider) \$35 Copay (Specialist)	No Copayment	Covered under Option 1	Not Covered
Syphilis Infection Screening <i>(For persons at increased risk and all pregnant women)</i>	\$10 Copay	No Copayment	Covered under Option 1	Not Covered
Well Child Evaluation with Immunization(s) <ul style="list-style-type: none"> <li>▪ Children over 24 months - 13 years</li> </ul>	\$10 Copay	No Copayment	Covered under Option 1	Not Covered
Well Child Evaluation with Immunization(s) <ul style="list-style-type: none"> <li>▪ Children older than 13 years of age</li> </ul>	\$10 Copay	No Copayment	Covered under Option 1	Not Covered
Well Child Evaluation Only <i>Children 0 -24 months</i>	\$10 Copay	No Copayment	Covered under Option 1	Not Covered
Well Child Evaluation Only <i>Children over 24 months</i>	\$10 Copay	No Copayment	Covered under Option 1	Not Covered

## Section Three - Covered Services

Preventive Services	HMO	HealthyBlue		
		Option 1	Option 2	Option 3
Iron Deficiency Anemia (Screening and Prevention) <i>(For asymptomatic children aged 6 to 12 months who are at increased risk for iron deficiency anemia)</i>	\$10 Copay	No Copayment	Covered under Option 1	Not Covered
Prophylactic Medication for Gonorrhea <i>(for all newborns)</i>	\$10 Copay	No Copayment	Covered under Option 1	Not Covered
Sickle Cell Disease Screening <i>(for newborns at risk for sickle cell disease)</i>	\$10 Copay	No Copayment	Covered under Option 1	Not Covered
Obesity Screening in Children and Adolescents <b>NOTE:</b> Coverage limited to screening provided by a Primary Care Provider in a primary care setting.	\$10 Copay	No Copayment	Covered under Option 1	Not Covered
Screening for Visual Impairment in Children Ages 1 – 5 Years (Once between ages 3 – 5 years to detect the presence of amblyopia or its risk factors.)	\$10 Copay	No Copayment	Covered under Option 1	Not Covered

### Prosthetics

**Prior Authorization may be required. See Section Two, Part H- Covered Services Requiring Prior Authorization.**

The following internal prosthetics are covered:

- Electronic heart pacemakers, intraocular lenses, and joints; and
- Post-operative breast prostheses following a mastectomy. See “Cosmetic and Reconstructive Surgery” in this section.

The following external prosthetics are covered:

- Prosthetic devices such as leg, arm, back or neck braces;
- Artificial legs, arms, or eyes including the initial purchase and replacements due to physical growth for a continuously covered Member and training necessary for use. Artificial limbs are limited to standard items and must be adequate to provide a reasonable level of functionality for normal daily activities; and
- Breast prostheses following a mastectomy.

Repairs, adjustments and duplicates of prosthetics are not covered. Replacements are covered when due to physical growth for a continuously covered Member.

## Section Three - Covered Services

	HMO	HealthyBlue		
		Option 1	Option 2	Option 3
Prosthetics	No Copay	\$20 per device/supply	Option 2 Deductible, then \$100 per device/supply	Option 3 Deductible, then \$150 per device/supply

### Rehabilitation Services (Outpatient Therapy)

Rehabilitation Services	HMO	HealthyBlue		
		Option 1	Option 2	Option 3
Physical, speech, or occupational therapy (Services limited to 30 visits for each therapy per diagnosis per Member per Plan Year)	\$25 Copay	\$20 per visit	Option 2 Deductible, then \$20 per visit	Option 3 Deductible, then \$20 per visit
		<i>Note: Benefits obtained under Option 1, Option 2 or Option 3 count against 30 visit limitation on physical, speech or occupational therapy.</i>		
All other Rehabilitation Services (Services limited to 30 visits for each therapy per diagnosis per Member per Plan Year)	\$35 Copay	Option 3 Deductible, then \$20 per visit	Option 2 Deductible, then \$100 per visit	Option 3 Deductible, then \$150 per visit
		<i>Note: Benefits obtained under Option 1, Option 2 or Option 3 count against 30 visit limitation on physical, speech or occupational therapy.</i>		

### Skilled Nursing Facility

Prior Authorization required. See Section Two, Part H - Covered Services Requiring Prior Authorization.

Skilled Nursing Facility Services	HMO	HealthyBlue		
		Option 1	Option 2	Option 3
Skilled Nursing Facility	No Copay (Limited to 100 days per Member per Plan Year)	Option 1 Deductible, then \$20 per day	Option 2 Deductible, then \$100 per day	Option 3 Deductible, then \$150 per day
		<i>Limited to 60 days per Member per Plan Year. Benefits obtained under Option 1, Option 2 or Option 3 count against 60 day limitation.</i>		

## Section Three - Covered Services

### Spinal Manipulation (Chiropractic) Services

Spinal Manipulation (Chiropractic) Services	HMO	HealthyBlue		
		Option 1	Option 2	Option 3
Spinal Manipulation (Chiropractic) Services (Limited to a maximum of 20 visits per Member per Plan Year)	\$35 Copay	\$20 per visit	Option 2 Deductible, then \$100 per visit	Option 3 Deductible, then \$150 per visit
		Note: Benefits obtained under Option 1, Option 2 or Option 3 count against 30 visit limitation on spinal manipulation.		

### Vision Examination (HealthyBlue Benefit Option Only)

One vision examination per Plan Year when obtained from the Vision Care Designee (Davis Vision). Vision examinations by a Health Care Provider other than the Vision Care Designee are **not** covered. A vision examination may include, but is not limited to:

- Case history;
- External examination of the eye and adnexa;
- Ophthalmoscopic examination;
- Determination of refractive status;
- Binocular balance testing;
- Tonometry test for glaucoma;
- Gross visual field testing;
- Color vision testing;
- Summary finding; and,
- Recommendation, including prescription of corrective lenses.

For purposes of the vision examination benefit only, the Allowed Benefit is:

- For the Vision Care designee, the Allowed Benefit for a covered service is the lesser of:
  - ▶ The actual charge, which, in some cases, will be a rate set by a regulatory agency; or
  - ▶ The benefit amount, according to the Vision Care Designee's rate schedule for the covered service or supply that applies on the date that the service is rendered.

The benefit payment is made directly to a Vision Care Designee. When a Member receives a vision examination from the Vision Care Designee, the benefit payment is accepted as payment in full, except for any applicable Copayment.

**Note:** The vision examination benefit provided under the HealthyBlue Benefit Option is limited. See Section Four – Exclusions and Limitations.

Vision Examination	HMO	HealthyBlue		
		Option 1	Option 2	Option 3
Vision Examination obtained through the Vision Care Designee (One examination per Plan Year)	Not Covered	\$10 Copay	Covered Under Option 1	Total charge, minus Plan payment of \$33

## Section Three - Covered Services

### C. Prescription Drug Program

By enrolling in the Plan, you are automatically covered under the Prescription Drug program. The Prescription Drug program is administered by the Plan Administrator in cooperation with Argus Health Systems, a pharmacy claims administrator. Argus Health Systems is an independent company and administers the Prescription Drug program on behalf of the Plan Administrator. The Prescription Drug program offers you the flexibility to purchase your medications either at a participating pharmacy or through a prescription mail order service. The participating pharmacy network includes most major drug and grocery stores and many smaller, independent pharmacies. All drug forms, quantities and strengths may not be covered or supplied under the Prescription Drug program. The status of some Prescription Drugs may change due to Plan decisions or actions by the Food and Drug Administration (FDA).

#### **Prescription Drug Deductibles**

##### *HMO Benefit Option*

Before the Plan pays for your Prescription Drugs, you will be required to meet any applicable annual Deductible. Under MHIP's HMO Benefit Option, you will have a separate Prescription Drug Deductible. The Prescription Drug Deductible is a fixed-dollar amount designated for you to pay for Prescription Drug benefits before the Plan begins to pay. You have a full Plan Year to satisfy the Deductible, depending on when you joined the Plan.

**Note:** Prescription Drug Deductibles and Copays count toward the Prescription Drug Out-of-Pocket Maximum under the HMO Benefit Option.

<b>Annual Pharmacy Deductible</b>	<b>HMO Benefit Option</b>
Individual	\$250
Family	\$500

##### *HealthyBlue Benefit Option*

Under the HealthyBlue Benefit Option, you must meet the Option 1 Deductible before the Plan begins to pay for covered Prescription Drugs. Prescription Drug and medical expenses are combined to meet the Combined Deductible.

<b>Annual Pharmacy Deductible</b>	<b>HealthyBlue Benefit Option</b>
Individual	Must meet Option 1 Deductible
Family	Must meet Option 1 Deductible

**NOTE:** Under the HealthyBlue Benefit Option, the entire combined Option 1 Deductible will count towards the Option 1 Out-of-Pocket Maximum.

#### **Prescription Drug Annual Maximum (HMO Benefit Option Only)**

The Prescription Drug Annual Maximum is the maximum dollar amount of Prescription Drug Covered Services payable by the Plan towards a Member's claims during a Plan Year.

	<b>HMO Benefit Option</b>
Prescription Drug Annual Maximum (per Member)	\$100,000

#### **How the Program Works**

Once your Prescription Drug Deductible is satisfied, you have two ways to purchase your medications through the Prescription Drug program:

- **Prescription Drugs that you take for a short time** – These must be filled at a participating pharmacy. Present your MHIP ID card and pay the appropriate Copay for up to a thirty-one (31) day (1 month) supply of your prescription. The pharmacy network includes most major drug and grocery stores and many smaller, independent pharmacies. You can verify that a pharmacy is participating with MHIP on MHIP's website at

## Section Three - Covered Services

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[www.marylandhealthinsuranceplan.state.md.us](http://www.marylandhealthinsuranceplan.state.md.us).

- **Prescription Drugs that you take on an ongoing or “maintenance” basis** (drugs that your physician or another Health Care Provider anticipates that you will need for six months or more for chronic conditions) – you can receive up to a ninety (90) day (3 month) supply of such medication mailed to your home through the Walgreens mail order program or at a participating pharmacy. However, Providers should not request a 90 day supply of medication when the prescription is filled for the first time.

### **Generic, Preferred Brand Name, Non-Preferred Brand Name and Select Brand Name Drugs**

To provide you with maximum flexibility, your Prescription Drug benefit provides coverage of Prescription Drugs at different levels. The amount that you pay out-of-pocket (your Copay) will vary for each of the following categories:

*Generic Drugs* - Generic Drugs generally save you the most money. A Generic Drug that is approved by the Food and Drug Administration meets the same quality standards as its Brand Name equivalent. Although the color and shape may be different, the active ingredients are the same and are therapeutically equivalent. For the HealthyBlue Benefit Option, Generic drugs include certain Preferred Preventive Drugs.

*Preferred Brand Name Drugs* - For flexibility and choice, MHIP has included many Brand Name medications to maximize your Prescription Drug benefit. Your Copayment for Preferred Brand Name Drugs may be higher than for Generic Drugs but less than you will pay for Non-Preferred Brand Name Drugs.

*Non-Preferred Brand Name Drugs* - These Brand Name Drugs will generally cost you more. You should discuss the possibility of using less costly Preferred Brand Name Drug alternatives with your physician and/or Health Care Provider.

*Select Brand Name Drugs* - These are brand name drugs that the plan has selected for placement on Tier 4.

The amount of your Copay depends on whether the prescribed medication is a Generic, Preferred Brand Name, Non-Preferred Brand Name or Select Brand Name drugs and which MHIP Benefit Option you choose. If you request a Brand Name Drug when a lower-cost generic equivalent is available, you will be required to pay the difference in price, *plus* the applicable Copay.

### **Prior Authorization**

Some drugs require Prior Authorization in advance of being dispensed. Please refer to the MHIP website at [www.marylandhealthinsuranceplan.state.md.us](http://www.marylandhealthinsuranceplan.state.md.us) for a list of drugs requiring Prior Authorization. Your physician or Health Care Provider must call Argus Health Systems at (800) 314-2872 and submit any required information by phone or by fax before prescribing these medications.

- If you go to the pharmacy to fill a prescription before your Health Care Provider obtains Prior Authorization for a drug that requires it, the pharmacy will not be able to fill the prescription.
- Your Health Care Provider must call Argus Health Systems at (800) 314-2872 and submit any required information by phone or by fax before prescribing these medications. Argus Health Systems will review the required information and make a decision to approve or, deny or with a potential recommendation for an alternative to the requested drug.
- If the Prescription Drug is approved, Argus Health Systems will enter an authorization for your local pharmacy to fill the drug. Your Health Care Provider will receive notification of the approval from Argus Health Systems.
- If the requested drug is denied, you and your Health Care Provider will receive a notification verbally and by letter describing your options for an Appeal.

If you have a question about this process, you can contact Member Services at (443) 725-1010 or toll free at (888) 456-2024. You can also call Argus Health Systems at (800) 241-3371.

### **Quantity Limits**

Some prescribed medications covered under MHIP have quantity limitations. Quantity limits means that only a set number and/or dosage per prescription is allowed based on clinically approved

## Section Three - Covered Services

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prescribing guidelines to ensure your safety. If your Health Care Provider prescribes a drug outside of established quantity limits, he or she must contact Argus Health Systems at (800) 314-2872.

Please refer to the MHIP website at [www.marylandhealthinsuranceplan.state.md.us](http://www.marylandhealthinsuranceplan.state.md.us) for the most up-to-date list of drug quantity limits. You can also receive these materials by calling Member Services at (443) 725-1010 or toll free at (888) 456-2024.

### **Using the Pharmacy Network**

When you need to fill a prescription, go to a participating pharmacy and show the pharmacist your MHIP ID card. You will not have to complete any claim forms as applicable Copays will apply once your Prescription Drug Deductible has been met. Please refer to the MHIP website at [www.marylandhealthinsuranceplan.state.md.us](http://www.marylandhealthinsuranceplan.state.md.us) for pharmacy locations.

If you fill your prescription at a non-participating pharmacy, you must pay 100% of the drug cost at the time of purchase and submit a claim form for reimbursement. Direct Reimbursement Claim Forms are available on the MHIP website at [www.marylandhealthinsuranceplan.state.md.us](http://www.marylandhealthinsuranceplan.state.md.us) or by calling Member Services at (443) 725-1010 or toll free at (888) 456-2024. See Section Two, Part M - Filing a Claim.

Reimbursement will be determined by prescription benefit coverage and Prior Authorization requirements.

### **Using the Mail Order Program**

The mail service Prescription Drug program, provided by Walgreens, is an integrated feature to your pharmacy benefits. It provides you with a convenient way to order medications through the mail. Your prescription is reviewed and dispensed by a registered pharmacist and is mailed directly to your home. The mail order program can provide up to a 90-day supply of medications for two Copays. However, it is recommended that prescriptions for short-term medications be obtained from a participating retail pharmacy. Call Walgreens Mail Order Service at 800-745-6285 for more information.

There may be times when you need a prescription for a maintenance drug filled immediately **but also know you will be taking it on an ongoing basis**. On this occasion, you should ask your doctor for two prescriptions: one for a 34-day supply that you can have filled immediately at a local pharmacy; and the other for up to a 90-day supply, plus refills, if appropriate, that you can send to Walgreens immediately.

In order to use the Walgreens mail order program, you must register. There are 4 ways to register with Walgreens Mail Service:

- **By mail.** Complete a "Registration & Prescription Order Form" that you can obtain by visiting [www.walgreensmail.com/carefirst](http://www.walgreensmail.com/carefirst) and submit this form along with your prescription that you need filled and any Copay to:

Walgreens Mail Service  
PO Box 628001  
Orlando, FL 32862-8001

- **On-Line.** You may register via the internet by visiting [www.walgreensmail.com/carefirst](http://www.walgreensmail.com/carefirst). Fill in the required information and submit. On-line registration may take up to 48 hours to become activated at Walgreens Mail Services. Once you have registered on-line, you may call Walgreens at 800-745-6285 to order your prescription refills when needed. You will need to provide the following information:
  - ▶ Prescription Benefit Provider:.....CareFirst BlueCross BlueShield.
  - ▶ Member ID Number:.....Up to 10 digits found on your identification card
  - ▶ Group Number:.....03000000
  - ▶ Mail Services Pharmacy:.....Orlando, FL
- **Via Fax from Doctor's Office.** Register by using the Walgreens Doctor Fax Order Form available from [www.walgreensmail.com/carefirst](http://www.walgreensmail.com/carefirst). Begin by filling out the Member/Patient areas on the right hand side of the form. Next, have your doctor fill out the prescription information

## Section Three - Covered Services

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and he or she can fax the form directly to Walgreens Mail Services. Please note that, to be valid, the Doctor Fax Order Form **must** be faxed from the doctor's office.

- **By Phone.** Call Walgreens Mail Services at (800) 745-6285 to register. After registering by phone, you can ask the Member Services Representative to process your prescription refill, if needed. You will be asked to provide your credit card number for any applicable Copay.  
**NOTE:** Please allow two weeks from the time you mail, fax or place your order until the time you receive your complete order at the address you specify.

Once you have ordered from Walgreens Mail Services, you'll have 4 refill options:

- Touch-tone: (800) 749-0009, 24 hours a day, 7 days-a-week
- Internet: [www.walgreensmail.com/carefirst.com](http://www.walgreensmail.com/carefirst.com) 24 hours a day, 7 days-a-week
- Telephone: Speak to a Member Services Representative at (800) 745-6285
- Mail: Send in a refill request slip provided in each order. When submitting a mail order for maintenance prescription obtained through the mail service, send your prescription to:

Walgreens Mail Service  
PO Box 628001  
Orlando, FL 32862-8001

*Special Restrictions* - Narcotics are not available through the mail order program. Some medications are limited in the amount that can be supplied at any one time; therefore, you might be unable to get a ninety (90) day supply. In these cases, you will be given no more than the amount allowed. Your Copay will cover only the supply that can be sent at any one time. Prescription Drugs are not available when the same drug is available Over-the-Counter. A Prescription Drug is considered to be the same as an Over-the-Counter medication if the Prescription Drug has the same ingredients, in the same concentration as the Over-the-Counter drug.

### **Member Services**

Toll-free numbers are available for your inquiries about your Prescription Drug benefits. Your calls are handled by representatives who have been formally trained to answer your inquiries. Be sure to have your identification card with you. For questions regarding your Prescription Drug benefits, you may call the following toll-free numbers for assistance.

- *Retail Pharmacy Program (Argus Health Systems):* (800) 241-3371 Monday through Friday, 8:30 a.m. to 12:00 midnight, and Saturday from 8:00 a.m. to 6:00 p.m., Eastern Time. Emergency pharmacy consultation is available seven days a week, 24 hours a day.
- *Mail Order Program (Walgreens):* (800) 745-6285
- *Mail Order Program Number for the Hearing-Impaired:* (800) 863-5488
- *For Vision-Impaired Members:* Upon special request with your mail order, the pharmacist will provide Braille labels for medication vials.

## **D. Mental Health and Substance Abuse Services**

Mental Health and Substance Abuse Services for MHIP are administered by the Plan Administrator in cooperation with Magellan Health Services ("Magellan"), an independent company. All Member services, including benefit clarifications, are provided by Member Services at (443) 725-1010 or toll free at (888) 456-2024. To obtain Prior Authorization, when required, for Mental Health and Substance Abuse services, you must call Magellan Health Services at (800) 245-7013. Magellan's core business hours are 8 a.m. to 6 p.m., Monday to Friday; however, Magellan is available 24 hours a day, 7 days a week for urgent/emergency issues.

**All Members** must call Magellan Health Services at (800) 245-7013 and obtain Prior Authorization prior to receiving **ALL** Outpatient, Intensive Outpatient, Partial Mental Health Hospitalization (PHP), or Inpatient Mental Health or Substance Abuse services. Any and all information relating to your health care history, diagnosis, condition, treatment, or evaluation is kept confidential.

**Emergency Services: Whenever you have a crisis, call Magellan's toll-free number, (800) 245-7013, 24 hours a day 7 days a week.** For life threatening emergencies, it is always recommended that Members call 911 to access emergency services in your area.

## Section Four- Exclusions and Limitations

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### What Is Not Covered By The Plan

If you have a question about whether or not other a services is excluded, contact Member Services at (443) 725-1010 or toll free at (888) 456-2024.

The Plan will not pay for expenses incurred by you for the following:

1. Services that are not Medically Necessary;
2. Services performed or prescribed under the direction of a person who is not a Health Care Provider;
3. Services that are beyond the scope of practice of the Health Care Provider performing the service;
4. Services to the extent they are covered by any government unit, except for veterans in Veterans' Administration or armed forces facilities for services received for which the recipient is liable;
5. Services for which you are not legally, or as a customary practice, required to pay for in the absence of a health benefit plan;
6. Routine vision care or examinations (except where specified in Section Three (Covered Services)) or the purchase, examination, or fitting of eye glasses or contact lenses, except for aphakic patients and soft or rigid gas permeable lenses or sclera shells intended for use in the treatment of a disease or injury;
7. Personal care services and domiciliary care services.
8. Services rendered by a Health Care Provider who is your spouse, mother, father, daughter, son, brother, or sister;
9. Experimental/Investigational services or drugs or Prescription Drugs prescribed or dispensed for Experimental/Investigational purposes;
10. Practitioner, Hospital, or clinical services related to radial keratotomy, myopic keratomileusis, and surgery which involves corneal tissue for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error;
11. In vitro fertilization, ovum transplants and gamete intrafallopian tube transfer, zygote intrafallopian transfer, or cryogenic or other preservation techniques used in these or similar procedures. Artificial insemination is excluded;
12. Services to reverse a voluntary sterilization procedure;
13. Services for sterilization or reverse sterilization for a Dependent minor;
14. Surgical treatment for obesity;
15. Medical treatment, surgical treatment, pharmacological treatment or regimen for reducing or controlling weight;
16. Services incurred before the Effective Date of coverage;
17. Services incurred after your termination of coverage, except as provided in any extension of benefits;
18. Surgery or related services for Cosmetic purposes to improve appearance, but not to restore bodily function or correct deformity resulting from disease, trauma, or congenital or developmental anomalies;
19. Services for injuries or diseases related to your job to the extent that you are required to be covered by a workers' compensation law;
20. Services rendered from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar persons or groups;
21. Personal hygiene and convenience items, including, but not limited to, air conditioners, humidifiers, furniture, or physical fitness equipment;
22. Charges for telephone consultations, failure to keep a scheduled visit, or completion of any form;
23. Inpatient admissions primarily for diagnostic studies, unless authorized by the Plan;
24. The purchase, examination, or fitting of hearing aids and supplies, and tinnitus maskers, except as provided in Section Three (Covered Services) in this Certificate;
25. Except for covered ambulance services, travel, whether or not recommended by a Health Care Provider;

## Section Four- Exclusions and Limitations

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26. Except for emergency services, services rendered while the Member is outside the United States;
27. Immunizations related to foreign travel;
28. Unless otherwise specified in Section Three (Covered Services), any type of dental care, work or treatment which includes, but is not limited to, routine examination or cleaning of the teeth, extractions of teeth, treatment of cavities, care of the gums or bones supporting the teeth, treatment of periodontal abscess, removal of impacted teeth, false teeth, or any other Hospital, professional care, or dental services or supplies in connection with:
  - The operation or treatment for the fitting or wearing of dentures;
  - Orthodontic care or malocclusion;
  - Dental implants; and
  - Operations on or for treatment of or to the teeth or supporting tissues of the teeth, except for:
    - ▶ Removal of tumors and cysts; or
    - ▶ Treatment of injury to natural teeth due to an accident if the treatment is received within 6 months of the accident;
29. Accidents occurring while and as a result of chewing;
30. Routine foot care, including the paring and removing of corns and calluses, or trimming of nails, unless these services are determined to be Medically Necessary;
31. Arch support, orthotic devices, in-shoe supports, orthopedic shoes, elastic supports, or exams for their prescription or fitting, unless these services are determined to be Medically Necessary for rehabilitation or habilitation purposes;
32. Inpatient admission primarily for physical therapy, unless authorized by the Plan;
33. Treatment leading to or in connection with transsexualism, or sex changes or modifications, including but not limited to surgery;
34. Treatment of sexual dysfunction not related to organic disease;
35. Services that duplicate benefits provided under federal, state or local laws, regulations, or programs;
36. Organ transplants, except for those included in Section Three (Covered Services) in this Certificate;
37. Non-human organs and their implantation;
38. Non-replacement fees for blood and blood products;
39. Lifestyle improvements, including nutrition counseling or physical fitness programs, unless included as a Covered Service;
40. Wigs or cranial prostheses;
41. Weekend admission charges, except for emergencies and maternity, unless authorized by the Plan;
42. Out-patient orthomolecular therapy, including nutrients, vitamins, and food supplements;
43. Temporomandibular joint syndrome (TMJ) treatment and treatment for craniomandibular pain syndrome (CPS), except for surgical services for TMJ and CPS, if Medically Necessary and if there is clearly demonstrable radiographic evidence of joint abnormality due to disease or injury;
44. Services for conditions that state or local laws, regulations, ordinances, or similar provisions require to be provided in a public institution;
45. Services for, or related to, the removal of an organ from a Member for purposes of transplantation into another person, unless the recipient is covered under the Plan and undergoing a covered transplant;
46. Physical examinations required for obtaining or continuing employment, insurance, or government licensing;
47. Non-medical ancillary services such as vocational rehabilitation, employment counseling, or educational therapy;
48. Private Hospital rooms, unless authorized by the Plan;
49. Private duty nursing, unless authorized by the Plan;

## Section Four- Exclusions and Limitations

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50. Treatment for Mental Health or Substance Abuse that requires Prior Authorization that is not authorized by the Plan Administrator, or for a Mental Health or Substance Abuse condition determined by the Plan Administrator to be untreatable;
51. Services related to smoking cessation;
52. Acupuncture;
53. Rest cures, residential, convalescent, or custodial care in a group home, halfway house or residential setting;
54. Marital counseling, educational therapy, behavior therapy, vocational therapy, coma-stimulation therapy, activities therapy, and recreational therapy;
55. Pastoral counseling;
56. Psychological testing for educational purposes;
57. Hypnosis for non-Diagnosis and Statistical Manual (DSM) classified disorders;
58. Treatment of conditions without recognizable DSM diagnostic classification (such as adult child of alcoholic families, "ACOA," "co-dependency");
59. Over-the-Counter medications and Prescription Drugs that have the same ingredients, in the same concentration, as an Over-the-Counter medication;
60. Vitamins, except CareFirst will provide a benefit for Prescription Drug:
  - Prenatal vitamins.
  - Fluoride and fluoride containing vitamins.
  - Single entity vitamins, such as Rocaltrol and DHT.
61. Prescription Drugs for Cosmetic use;
62. Prescription Drugs for weight loss;
63. Work Hardening Programs. Work Hardening Program means a highly specialized rehabilitation program designed to simulate workplace activities and surroundings in a monitored environment with the goal of conditioning the participant for a return to work; and
64. Any service not specified as a Covered Service in Section Three of this Certificate.
65. The following services are excluded from coverage for vision examination (covered for HealthyBlue Benefit Option Members only)
  - Diagnostic services, except as listed in the schedule of benefits
  - Medical care or surgery. Covered services related to medical conditions of the eye are covered separately under this HMO Certificate of Coverage and are excluded from the vision examination benefit.
  - Prescription drugs obtained and self-administered by the Member for outpatient use unless the prescription drug is specifically covered this HMO Certificate of Coverage.
  - Services or supplies not specifically approved by the Vision Care Designee where required in Schedule of Benefits.
  - Orthoptics, vision training and low vision aids.
  - Glasses, sunglasses and contact lenses.
  - Vision Care services for cosmetic use.
  - Services obtained from Non-Contracting or Out-of-Network Providers.

## Section Five – Member Rights and Responsibilities

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### MHIP Member Rights and Responsibilities

- Members have a right to be treated with respect and recognition of their dignity and right to privacy.
- Members have a right to receive information about the Plan, its services, its practitioners and Providers, and Members' rights and responsibilities.
- Members have a right to participate with practitioners in decision making regarding their health care.
- Members have a right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- Members have a right to make recommendations regarding the Plan's Members' rights and responsibilities policy.
- Members have a right to voice complaints or Appeals about the Plan or the care provided.
- Members have a responsibility to provide, to the extent possible, information that the Plan and its practitioners and Providers need in order to care for them.
- Members have a responsibility to understand their health problems and participate in developing mutually agreed upon treatment goals to the degree possible.
- Members have a responsibility follow the plans and instructions for care that they have agreed on with their Providers.
- Members have a responsibility to pay Member Copayments or Coinsurances at the time of service.
- Members have a responsibility to keep and be on time for appointments and to notify Providers when an appointment must be cancelled.
- Members have a responsibility to notify the Plan immediately if they have or become eligible for Medicare, Medicaid or any other health insurance.
- Members have a responsibility to notify the Plan if they relocate out of state.
- Members have a responsibility to keep their MHIP ID card with them and to present it to a Health Care Provider or a Health Care Facility at the time of service.

## Section Six – Definitions

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The definitions in this section are for terms used in this HMO Certificate of Coverage.

**Accidental Injury** – Bodily injury resulting from a sudden, violent, unexpected, and external event. Accidental Injury does not include poisoning, disease, or any type of infection.

**Adverse Decision** – A Utilization Review determination that a (i) proposed or delivered Health Care Service that is otherwise a Covered Service is not or was not Medically Necessary, appropriate or efficient; and (ii) may result in non-coverage of the Health Care Service. Adverse Decisions do not include determinations about a person's eligibility status as a Member..

**Allowable Expenses** - See definition in Section Two, Part O – Coordination of Benefits.

**Allowed Benefit** –

### **For the HMO Benefit Option**

#### *For a Contracting Provider*

The Allowed Benefit payable to a Contracting Provider for a Covered Service will be the lesser of:

- The Contracting Provider's actual charge, which, in some cases, will be a rate set by a regulatory agency; or
- The benefit amount, agreed upon between CareFirst BlueChoice and the Contracting Physician or Contracting Provider that applies on the date that the Covered Service is rendered.

The benefit payment is made directly to the Contracting Provider and is accepted as payment in full, except for the Copayment and Coinsurance amounts stated in the Schedule of Benefits. The Member is responsible for any applicable Copayment and Coinsurance as stated in the Schedule of Benefits, and the Contracting Provider or Contracting Provider may bill the Member directly for such amounts.

#### *For a Non-Contracting Provider*

The Allowed Benefit for a Covered Service will be determined in the same manner as the Allowed Benefit for a Participating Provider. The benefit is payable to the Member or to the provider, at the discretion of CareFirst. The Member is responsible for any applicable Copayment and Coinsurance amounts and for the difference between the Allowed Benefit and the Practitioner's actual charge.

#### *For a Non-Contracting Health Care Facility*

The Allowed Benefit for a Covered Service is based upon the lower of the Non-Contracting Health Care Facility's actual charge or the established Allowed Benefit if one has been established for that type of eligible provider and service. In some cases, and on an individual basis, the Plan is able to negotiate a lower rate with an Eligible Provider. In that instance, the Plan payment will be based on the negotiated fee and the provider agrees to accept the amount as payment in full except for any applicable Copayment and Coinsurance amounts, for which the Member is responsible. The benefit is payable to the Member or to the Non-Contracting Health Care Facility, at the discretion of the Plan. The Member is responsible for any applicable Copayment and Coinsurance amounts and, unless negotiated as stated above, for the difference between the Allowed Benefit and the Non-Contracting Health Care Facility's actual charge. It is the Member's responsibility to apply any Plan payments to the claim from the Non-Contracting Health Care Facility.

### **For the HealthyBlue Benefit Option**

#### *In-Network Benefits*

For an In-Network Provider, the Allowed Benefit for a Covered Service is the lesser of:

- The Provider's actual charge which, in some cases, will be a rate set by a regulatory agency; or
- The benefit amount, according to the Plan Administrator's rate schedule, for the Covered Service that applies on the date that the service is rendered.

## Section Six – Definitions

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The benefit payment is made directly to the in-Network Provider and is accepted as payment in full, except for any Member payment amounts stated in the Schedule of Benefits. The Member is responsible for any applicable Deductible, Copayment and Coinsurance stated in the Schedule of Benefits, and the In-Network Provider may bill the Member directly for such amounts.

### *Out-of-Network Benefits*

For an Out-of-Network Participating Provider, the Allowed Benefit for a Covered Service is the lesser of:

- The Out-of-Network Participating Provider's actual charge which, in some cases, will be a rate set by a regulatory agency; or
- The benefit amount, according to the Plan Administrator's rate schedule, for the Covered Service that applies on the date that the service is rendered.

The benefit is payable to the Out-of-Network Participating Provider and is accepted as payment in full, except for any applicable Member payment amounts stated in the Schedule of Benefits. The Member is responsible for any applicable Deductible, Copayment and Coinsurance stated in the Schedule of Benefits, and the Out-of-Network Participating Provider may bill the Member directly for such amounts.

**For an Out-of-Network Non-Participating Hospital in the State of Maryland**, the Allowed Benefit for a Covered Service is a rate set by the state regulatory agency.

**For an Out-of-Network Non-Participating Provider (except for an Out-of-Network Non-Participating hospital in the State of Maryland)**, the Allowed Benefit for a Covered Service is the lesser of:

- The provider's actual charge which, in some cases, will be a rate set by a regulatory agency; or
- The benefit amount, according to the CareFirst BlueCross BlueShield rate schedule, for the Covered Service that applies on the date that the service is rendered.

Benefits may be paid to the Member or to the Out-of-Network Non-Participating Provider at the discretion of CareFirst BlueChoice. The Member is responsible for any applicable Deductible, Copayment and Coinsurance amounts and the difference between the Allowed Benefit and the actual charge. When benefits are paid to the Member, it is the Member's responsibility to apply any Plan payments to the claim from the Out-of-Network Non-Participating Provider.

**For Prescription Drugs (under either the HMO or HealthyBlue Benefit Option)**, The Allowed Benefit for covered Prescription Drugs is the lesser of:

- The pharmacy's actual charge; or
- The benefit amount, according to the Plan's fee schedule, for covered Prescription Drugs that applies on the date that the service is rendered.

If the Member purchases a covered Prescription Drug or Diabetic Supply from a participating pharmacy, the benefit payment is made directly to the participating pharmacy and is accepted as payment in full, except for any applicable Deductible, Copayment or Coinsurance as stated in this rider. The Member is responsible for any applicable Deductible, Copayment or Coinsurance and the participating pharmacy may bill the Member directly for such amounts.

If the Member purchases a covered Prescription Drug or Diabetic Supply from a non-participating pharmacy, the Member is responsible for paying the total charge and submitting a claim to the Plan for reimbursement. Members will be entitled to reimbursement from the Plan up to the amount of the Allowed Benefit, minus any applicable Deductible, Copayment or Coinsurance. Members may be responsible for balances above the Allowed Benefit.

**For vision examination benefits (available to HealthyBlue Benefit Option Members only)**, the Allowed Benefit is:

## Section Six – Definitions

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- For the Vision Care designee, the Allowed Benefit for a covered service is the lesser of:
  - ▶ The actual charge, which, in some cases, will be a rate set by a regulatory agency; or
  - ▶ The benefit amount, according to the Vision Care Designee's rate schedule for the covered service or supply that applies on the date that the service is rendered.

**Alternate Recipient** - A child of a Subscriber who is recognized under a qualified medical child support order (QMCSO) as having a right to enrollment under the Plan.

**Annual Maximum** – See Prescription Drug Annual Maximum.

**Appeal** – A protest filed by you or your Health Care Provider on your behalf regarding a Coverage Decision, a Termination of Coverage for Non-Eligibility or Non-Payment or a Denial of Change in Benefit Options.

**Appeal Decision** – “A final determination from an Appeal of a Coverage Decision, or the Plan Administrator's determination about appeals relating to Denial of Eligibility, Termination of Coverage for Non-Eligibility or Non-Payment or Denial of Change in Benefit Options.

**Benefit Option** - One of the following Plan options authorized by the Maryland Health Insurance Plan Board of Directors:

- HMO Benefit Option
- HealthyBlue Benefit Option

**Brand Name Drug** – A Prescription Drug that has been given a name by a manufacturer or distributor to distinguish it as produced or sold by a specific manufacturer or distributor and that may be used and protected by a trademark.

**Care Coordination Team** - The Health Care Providers involved in the collaborative process of assessment, planning, facilitation and advocacy for options and services to meet the Member's health needs through communication and available resources to promote quality cost-effective outcomes.

**Care Plan** - The plan directed by a Health Care Provider, and coordinated by a nurse coordinator and Care Coordination Team, with engagement by the Qualifying Individual. The Care Plan is created in accordance with the PCMH goals and objectives.

**COBRA Coverage** – Employer health coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, for which you may pay the full cost in order to extend your coverage as a result of certain qualifying events, such as termination of employment or divorce.

**Coinsurance** – The percentage of the Allowed Benefit allocated between the Plan and the Member whereby the Plan and the Member share in the payment for Covered Services.

**Complaint** – A protest filed with the Maryland Insurance Commissioner involving an Adverse Decision, Coverage Decision, Appeal Decision or Grievance Decision..

**Condition Management Referral** - A referral by a Primary Care Provider that allows a Specialist to act as a Primary Care Provider solely for the condition for which the Member of the HMO Benefit Option was referred and only for the authorized treatment period. The Specialist shall be permitted to provide and coordinate the primary and specialty care for the Member's condition and includes authorizing such referrals, procedures, tests, and other medical services as the Member's Primary Care Provider would otherwise be permitted to provide or authorize.

## Section Six – Definitions

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**Contracting Physician** - A licensed physician who has entered into a contract with CareFirst BlueChoice to provide services to Members of the HMO Benefit Option and who has been designated by CareFirst BlueChoice as a Contracting Physician.

**Contracting Provider** - Any Health Care Provider or Health Care Facility that has entered into a contract with CareFirst BlueChoice and has been designated by CareFirst BlueChoice to provide services to Members of the HMO Benefit Option.

**Controlled Clinical Trial** – Treatment that is approved by an institutional review board; conducted for the primary purpose of determining whether or not a particular treatment is safe and efficacious; and approved by an institution or center of the National Institutes of Health, the Food and Drug Administration, the Department of Veterans' Affairs, or the Department of Defense.

**Copayment/Copay** – The dollar amount that a Member must pay for certain Covered Services. When a Member receives multiple services on the same day by the same Provider, the Member will only be responsible for one Copayment.

**Cosmetic** – The use of a service or supply which is provided with the primary intent of improving appearance, not restoring bodily function or correcting deformity resulting from disease, trauma, or previous therapeutic intervention, as determined by the Plan.

**Coverage Decision** – An initial determination that results in non-coverage of a Health Care Service. A Coverage Decision includes nonpayment of all or any part of a claim. It does not include an Adverse Decision..

**Covered Individual** – You and any or all Dependent(s) covered under this Plan.

**Covered Services** – Medically Necessary Health Care Services and supplies provided by or through the Plan, subject to all Plan terms, conditions, limitations, and exclusions.

**Deductible** – The dollar amount of the Allowed Benefits for Covered Services that must first be incurred by the Member during a Plan Year before the Plan will make payments for Covered Services.

**Dependent** – Dependent includes:

- A lawful spouse;
- An unmarried child who is less than age 23 and is a biological child, stepchild, or foster child;
- A lawfully adopted unmarried child (or child in the process of being adopted) who is less than age 23, as of the date of placement for adoption;
- An unmarried child who is less than age 23 for whom you have been granted legal custody, including custody as a result of guardianship, other than a temporary guardianship of less than 12 months duration, granted by a court or testamentary appointment;
- An unmarried child who is less than age 23 for whom you have the legal obligation to provide coverage pursuant to court order, court-approved agreement, or testamentary appointment; and
- An unmarried child who is over the age of 23 but is incapable of self-support because of mental or physical incapacity that began before the child attained the limiting age.

**Effective Date** – A Subscriber's beginning date of coverage under the Plan, including, but not limited to, the beginning date of coverage under an MHIP+ Benefit Option.

**Emergency Case** - A case involving an Adverse Decision for which an expedited review is required for services proposed, but not delivered, and the services proposed are necessary to treat a condition or illness that without immediate medical attention would seriously jeopardize your life or health or your ability to regain maximum function or would cause you to be a danger to

## Section Six – Definitions

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yourself or others. A designated Registered Nurse will determine whether an Emergency Case exists.

**Emergency Services** - Care provided after the sudden and unexpected onset of a medical condition of sufficient severity, including severe pain, when the absence of immediate medical attention could reasonably be expected by a prudent layperson that possesses an average knowledge of health and medicine to result in:

- Serious jeopardy to the mental or physical health of the individual; or
- Danger of serious impairment of the individual's bodily functions; or
- Serious dysfunction of any of the individual's bodily organs; or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Examples might include, but are not limited to, heart attacks, uncontrollable bleeding, inability to breathe, loss of consciousness, poisonings, and other acute conditions as CareFirst BlueChoice determines.

**Experimental/Investigational** – A service or supply that is in the developmental stage and in the process of human or animal testing, excluding Controlled Clinical Trials. Services or supplies that do not meet all five of the criteria listed below are deemed to be Experimental/Investigational:

- The Technology\* must have final approval from the appropriate government regulatory bodies;
- The scientific evidence must permit conclusions concerning the effect of the Technology on health outcomes;
- The Technology must improve the net health outcome;
- The Technology must be as beneficial as any established alternatives; and,
- The improvement must be attainable outside the investigational settings.

\*Technology includes drugs, devices, processes, systems, or techniques. A drug is not considered Experimental/Investigational as long as it is used to treat a covered indication; it has been approved by the FDA for at least one indication; and, it is recognized for treatment of the covered indication in one of the standard reference compendia or in substantially accepted peer review medical literature.

**Filing Date** – The earlier of (i) Five (5) days after the date of mailing; or (ii) the date of receipt.

**Generic Drug** – means any Prescription Drug approved by the FDA that has the same bio-equivalency as a specific Brand Name Drug.

**Grace Period** – The period of 60 days following the due date of a Premium, other than the first Premium payable by an individual applying for coverage under the Plan, during which an individual may pay the Premium to the Plan administrator and coverage continues under the Plan, without lapse.

**Grievance** – A protest filed by you or your Health Care Provider on your behalf regarding an Adverse Decision.

**Grievance Decision** – A protest filed by you or your Health Care Provider on your behalf regarding an Adverse Decision.

**Health Advocacy Unit** - The Health Education and Advocacy Unit in the Division of Consumer Protection of the Office of the Attorney General.

**Health Care Facility** - A Hospital, ambulatory surgical facility or center, Inpatient rehabilitation facility, home health agency, skilled nursing facility, hospice facility, hospice program or Partial Hospitalization program that is licensed or certified, or both, to operate within the jurisdiction in which it is located.

**Health Care Provider** – A physician, dentist (D.D.S. or D.M.D.) or other Provider of health care

## Section Six – Definitions

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such as: a chiroprapist, chiropractor, doctor of podiatry, doctor of surgical chiropody, nurse anesthetist, nurse midwife, nurse practitioner, optician, optometrist, physical therapist, physiotherapist, audiologist, psychologist and social worker.

**Health Care Service** – A health or medical care procedure or service rendered by a Health Care Provider or Health Care Facility, including:

- Testing, diagnosis, or treatment of a human disease or dysfunction; and,
- Dispensing drugs, medical devices, medical appliances, or medical goods for the treatment of a human disease or dysfunction.

**Health Insurance Portability and Accountability Act (HIPAA)** – A federal law that among other things, limits the use of Pre-Existing Condition exclusions, waiting periods, and health status exclusions. HIPAA also regulates an organization’s policies and procedures covering the privacy of, and access to, patient health information.

**Health Maintenance Organization (HMO)** – A Plan Benefit Option that uses a network of Contracting Providers. Primary Care Providers serve as care coordinators, authorizing Plan coverage for certain specialty services. If you elect to seek care outside of the CareFirst BlueChoice provider network (except for Urgent Care or Emergency Services), then you will usually not be reimbursed for the cost of the treatment.

**Home Health Care** – The Health Care Services provided during a visit by a Home Health Agency to patients confined at home due to an illness or injury requiring skilled Health Care Services on an intermittent, part-time basis.

**Hospice** – An agency or organization that administers a program of palliative and supportive Health Care Services providing physical, psychological, social, and spiritual care for terminally ill persons assessed to have a life expectancy of six (6) months or less. Hospice care is intended to let the terminally ill spend their last days with their families at home (Outpatient hospice services) or in a home-like setting (Inpatient Hospice services), with emphasis on keeping the patient as comfortable and free from pain as possible, and providing emotional support to the patient and his or her family.

**Hospital** - Any facility in which the primary function is the provision of diagnosis, treatment, and medical and nursing services, surgical or non-surgical and that is:

- Licensed by the appropriate State authorities; or
- Accredited by the Joint Commission on Accreditation of Healthcare Organizations; or,
- Approved by Medicare.

**Illness** – For purposes of this Plan, an Illness is a bodily disorder or disease, mental illness, substance abuse, accidental bodily injury, or pregnancy. All Accidental Injuries sustained by an individual in a single accident, or all Illnesses that are due to the same or related cause are considered as one Illness.

**In-Network Provider** - A physician, Health Care Provider or Health Care Facility that has contracted with CareFirst BlueChoice, Inc. to render Covered Services to Members of the HMO and HealthyBlue Benefit Options. In-Network Provider relates only to method of payment, and does not imply that any physician, Health Care Provider or Health Care Facility is more or less qualified than another. The fact that a physician, Health Care Provider or Health Care Facility is a Contracting Provider does not mean that the physician, Health Care Provider or Health Care Facility is an In-Network Provider. With the exception of Emergency Services, Urgent Care and follow-up care after emergency surgery, In-Network Provider services are only available within the CareFirst BlueChoice Service Area.

A listing of In-Network Providers will be provided to the Member at the time of enrollment and is also available from CareFirst BlueChoice upon request. The listing of In-Network Providers is subject to change. Members may confirm the status of any physician, health care professional or health care facility prior to making arrangements to receive care by contacting CareFirst

## Section Six – Definitions

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BlueChoice for up-to-date information.

**Inpatient** – An admission to a Hospital as a bed-patient in which Room and Board Charges are incurred.

**Intensive Outpatient** – A treatment program offering a coordinated plan of clinical services and modalities delivered in an Outpatient ambulatory setting.

**Lifetime Maximum** - The maximum dollar amount of medical and Prescription Drug Covered Services payable by the Plan toward a Member's claims during a Member's lifetime.

**Maintenance Drug** – A Maintenance drug is a Prescription Drug anticipated by your health care prescriber to be required for six (6) months or more to treat a chronic condition.

**Medical Necessity or Medically Necessary** – Health Care Services or supplies that a Health Care Provider, exercising prudent clinical judgment, renders to or recommends for, a patient for the purpose of preventing, evaluating, diagnosing or treating an Illness, injury, disease or its symptoms. These Health Care Services or supplies are:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for a patient's Illness, injury or disease;
- Not primarily for the convenience of the patient, physician or other Health Care Provider; and
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results in the diagnosis or treatment of that patient's Illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations and views of Health Care Providers practicing in relevant clinical areas, and any other relevant factors.

The fact that a Health Care Provider may prescribe, authorize, or direct a service does not of itself make it Medically Necessary or covered by this Certificate of Coverage. Medical Necessity is determined by the Plan.

**Medicare** – Medical benefits provided by Title XVIII of the Social Security Act of 1965, as amended from time to time.

**Medicaid** – A federally-funded, state-operated and administered program authorized by Title XIX of the Social Security Act of 1965, as amended from time to time.

**Medical Benefit Out-of-Pocket Maximum** –For the Healthy Blue Benefit Option, the Medical Benefit Out-of-Pocket Maximum is the maximum amounts that the Member will have to pay for Covered Services, except for Prescription Drugs covered under to the Plan's Prescription Drug program, in any Plan Year. Once the Member meets the Medical Benefit Out-of-Pocket Maximum, the Member will no longer be required to pay Copayments or his or her share of the Coinsurance for Covered Services, except for Prescription Drugs, for the remainder of that Plan Year.

For the HDP Benefit Option, the Medical Benefit Out-of-Pocket Maximum is the maximum amount that the Member will have to pay for Covered Services, including Prescription Drugs covered under to the Plan's Prescription Drug program, in any Plan Year. Once the Member meets the Medical Benefit Out-of-Pocket Maximum, the Member will no longer be required to pay Copayments or his or her share of the Coinsurance for Covered Services, including Prescription Drugs, for the remainder of that Plan Year.

## Section Six – Definitions

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**Medically Uninsurable Individual-** An individual who is a resident of the State of Maryland and who:

- Provides evidence that, for health reasons, a carrier has refused to issue substantially similar coverage to the individual;
- Provides evidence that, for health reasons, a carrier has refused to issue substantially similar coverage to the individual, except at a rate that exceeds the Plan rate;
- Satisfies the definition of “eligible individual” under Insurance Article Section 15-1301, Annotated Code of Maryland;
- Has a history of or suffers from a medical or health condition that is included on a list promulgated by the Board via regulation;
- Is eligible for the tax credit for health insurance costs under Section 35 of the Internal Revenue Code; or
- Is a Dependent of an individual who is eligible for coverage under the Plan.

“Medically Uninsurable Individual” does not include an individual who is eligible for coverage under:

- The federal Medicare program;
- The Maryland Medical Assistance Program (Medicaid);
- The Maryland Children’s Health Program; or
- An employer-sponsored group health insurance plan that includes benefits comparable to Plan benefits, unless the individual is eligible for the tax credit for health insurance costs under Section 35 of the Internal Revenue Code and your employer pays less than 50% of the cost of the coverage. This does not include a person who is eligible for employer-sponsored group health insurance, but is unable to activate such coverage during a mandatory initial waiting period.

**Member** – You, and/or your eligible Dependent(s) who have coverage that has become effective under the Plan.

**Mental Health** – Counseling, psychological, psychiatric, Substance Abuse, or other treatments for conditions related to mental illness and/or Substance Abuse.

**MHIP Application** – The Maryland Health Insurance Plan Enrollment Application Form.

**MHIP+** - See Premium Subsidy Program.

**Non-Contracting Provider-** A Health Care Provider that is not a member of the CareFirst BlueChoice Provider network.

**Non-Preferred Brand Name Drug** – A drug that the Plan has not designated as a Preferred Brand Name Drug.

**Open Enrollment** – The designated month each year in which you may elect to transfer from one MHIP Benefit Option or Type of Coverage to another.

**Orthotic (Appliance or Device)** – A type of corrective appliance designed to support a weakened body part, including, but not limited to specially designed corsets, leg braces, and extremity splints.

**Outpatient** – Service for a diagnosis or treatment at a Health Care Facility or physician’s office that does not incur room and board charges.

**Out-of-Network Provider** – Any physician, health care professional or health care facility that is not an In-Network Provider (applicable to the HealthyBlue Benefit Option only).

**Out-of-Network Non-Participating Provider** - An Out-of-Network Provider who does not participate in the CareFirst BlueCross BlueShield Preferred Provider network (applicable to the HealthyBlue Benefit Option only).

## Section Six – Definitions

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**Out-of-Network Participating Provider** – An Out-of-Network Provider who participates in the CareFirst BlueCross BlueShield Preferred Provider network (applicable to the HealthyBlue Benefit Option only).

**Over-the-Counter** – Any item or supply, as determined by the Plan, that is available for purchase without a prescription, unless otherwise a Covered Service. This includes, but is not limited to, non-prescription eye wear, family planning and contraception products, cosmetics or health and beauty aids, food and nutritional items, support devices, non-medical items, foot care items, first aid and miscellaneous medical supplies (whether disposable or durable), personal hygiene supplies, incontinence supplies, and Over-The-Counter medications and solutions.

**Partial Hospitalization** – Intensive treatment in a medically supervised setting with the opportunity for the Member to return home or to another residential setting at night. Services are usually offered three (3) to five (5) times per week for more than several hours per day.

**Partial Mental Health Hospitalization (PHP)** - This is a facility based Outpatient service. Programming for this level of care lasts 6-8 hours per day, 3-5 days per week. Patients at this level of care will participate in individual and group counseling, and will have regular (if not daily) contact with a psychiatrist for medication management.

**Plan** – The Maryland Health Insurance Plan (MHIP), and its agents, employees, business associates, and contractors, include any sub-contractor of a business associate or contractor. MHIP is a state-administered health program operating as an independent agency of the Maryland Insurance Administration under the direction of the Board of Directors of the Maryland Health Insurance Plan.

**Plan Administrator** – CareFirst BlueChoice, Inc. which is the entity contracted with MHIP as the third party administrator of the Plan under COMAR 31.17.01.03.

**Plan Year** – The twelve consecutive months beginning July 1 and ending on June 30.

**Pre-Existing Condition** – A medical condition which you or your Dependent has been diagnosed, received care or treatment for, or been advised to receive care or treatment for within the six-month period immediately prior to your Plan Effective Date.

**Preferred Brand Name Drug** – A Prescription Drug that the Plan has designated on its preferred drug list.

**Preferred Preventive Drug** - A Prescription Drug that is included on the CareFirst BlueChoice Preferred Preventive Drug List. (Applicable to Prescription Drug benefits under the HealthyBlue Benefit Option only).

**Preferred Preventive Drug List** - The list issued by MHIP of certain preventive Prescription Drugs related to diabetes, high cholesterol, high blood pressure (hypertension), depression or asthma. Not all preventive Prescription Drugs are included on the Preferred Preventive Drug List. MHIP may change this list periodically without notice to Members. A copy of the Preferred Preventive Drug List is available to the Member upon request. (Applicable to Prescription Drug benefits under the HealthyBlue Benefit Option only).

**Premium** – The monthly sum due to the Plan from Subscribers and Members in order for coverage under the Plan remain in force.

**Premium Subsidy Program** – The Maryland Health Insurance Plan Premium Subsidy Program is also known as MHIP+. MHIP+ is a program that provides low to moderate-income MHIP Members with Premium assistance. The program is only available to those Members whose household income is at or below 300% of Federal income guidelines.

## Section Six – Definitions

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**Prescription Drug** A drug, biological, or compounded prescription dispensed by a pharmacist or pharmacy intended for administration or use by the Member that carries the FDA legend “may not be dispensed without a prescription;” and, drugs prescribed for treatments other than those stated in the labeling approved by the FDA, if the drug is recognized for such treatment in standard reference compendia or in the standard medical literature. For purposes of this Certificate, Prescription Drug includes the diabetic equipment and supplies described in the Prescription Drugs section of the Schedule of Benefits and does not include blood or blood products described in the Blood & Blood Products section of the Schedule of Benefits. See Section Three, Part B – Schedule of Benefits.

**Prescription Drug Annual Maximum** – The Prescription Drug Annual Maximum is the maximum dollar amount of Prescription Drug Covered Services payable by the Plan towards a Member’s claims during a Plan Year.

**Prescription Drug Out-of-Pocket Maximum** –For the HMO Benefit Option, the maximum amount that the Member will have to pay for Prescription Drugs covered under the Plan’s Prescription Drug program in any Plan Year. Once the Member meets the Prescription Drugs Out-of-Pocket Maximum, the Member will no longer be required to pay Copayments for Prescription Drugs for the remainder of that Plan Year. There is no separate Prescription Drug Out-of-Pocket Maximum applicable to the HDP Benefit Option.

**Primary Care Medical Home Program (“PCMH”)** - Medical and associated services directed by the PCMH team of medical professionals to:

- Foster the Health Care Provider’s partnership with a Qualifying Individual and, where appropriate, the Qualifying Individual’s primary caregiver;
- Coordinate ongoing, comprehensive health care services for a Qualifying Individual; and,
- Exchange medical information with CareFirst BlueChoice, other providers and Qualifying Individuals to create better access to health care, increase satisfaction with medical care, and improve the health of the Qualifying Individual.

**Primary Care Provider (PCP)** – A licensed physician who is a Contracting Provider and whose specialty is Family Practice, General Practice, Internal Medicine, Pediatrics, and/or Obstetrics/Gynecology.

**Prior Authorization** – The approval a Member, or Provider acting on a Member’s behalf, must seek and receive in advance from the Plan in order for services or Prescription Drugs that require Prior Authorization to be Covered Services. Prior Authorization includes Utilization Review. See Section Two, Parts G (Prior Authorization Requirements) and H (Covered Services Requiring Prior Authorization).

**Provider** – A Health Care Provider or a Health Care Facility licensed or otherwise authorized by law to provide Health Care Services.

**Qualifying Individual** - a Member with a chronic condition, serious illness or complex health care needs, as determined by CareFirst BlueChoice, requiring coordination of health services and who agrees to participate in the Primary Care Medical Home Program.

**Referral** - means a written authorization issued by a Primary Care Provider that allows the Member to obtain services from a Specialist

**Select Brand Name Drugs** – Brand name drugs that the Plan has selected for placement on the fourth Copayment tier.

**Service Area** - The geographic area within which CareFirst BlueChoice’s In-Network services are available, with the exception of emergency and urgent care services. CareFirst BlueChoice may amend the defined Service Area at any time by notifying the Subscriber in writing.

## Section Six – Definitions

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**Specialist** - A licensed physician who is certified or eligible for certification by the appropriate specialty board and trained in practice in a specified field of medicine.

**Standing Referral** - A referral by a Primary Care Provider to a Specialist that does not have a specified treatment period. The referral is subject to periodic review by the Primary Care Provider and the Plan Administrator to determine whether the Standing Referral continues to be Medically Necessary.

**Subscriber** – The primary Member responsible for Premium payment and whose eligibility is the basis for participation in the Plan.

**Substance Abuse** – An illness characterized by a physiological or psychological dependency, or both, on a controlled substance and/or alcoholic beverage. It is further characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user's health is substantially impaired or endangered or your social or economic function is substantially disrupted.

**Substantially Similar Coverage** – Coverage under any health plan providing Hospital, medical, or surgical benefits on an expense incurred basis issued by an insurer, by a nonprofit health service plan, a health maintenance organization, or an employer-sponsored plan that provides health benefits to the employees of the employer.

**Transplant Facility** – A facility, Hospital or Health Care Provider providing transplant services under the Plan.

**Type of Coverage** - One of the following Types of Coverage authorized by the Maryland Health Insurance Plan Board of Directors:

- **Subscriber Only** – MHIP will cover you, the Subscriber, only.
- **Subscriber and Spouse** – MHIP will cover you and your spouse.
- **Subscriber and Child(ren)** – MHIP will cover you and one or more unmarried Dependent children under the age of 23.
- **Subscriber and Family** – MHIP will cover you, your spouse, and any unmarried Dependent children under the age of 23.

**Urgent Care** – Medical treatment for conditions that require prompt medical attention, but are not life-threatening emergencies.

**Utilization Review** – The Prior Authorization process by which the Plan determines whether a Covered Service is Medically Necessary. Utilization Review involves review of medical records by a licensed physician or medical professional.

**Vision Care Designee** means the entity with which the Plan or the Plan Administrator has contracted to administer the vision examination benefit for HealthyBlue Benefit Option members only. The Vision Care Designee is Davis Vision.

**You and/or your** – For the purposes of this Certificate of Coverage, “you” or “your” refers to you (the Subscriber) and/or any of your Dependent(s)