

## TEMPORARY FEDERAL HIGH RISK POOL BENEFIT OPTION ENDORSEMENT

### Maryland Health Insurance Plan Endorsement to the Certificate of Coverage

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This Endorsement is effective September 1, 2010 or upon the Effective Date of the Certificate of Coverage to which it is attached, whichever is later.

This Endorsement is issued to Subscribers enrolled in the Temporary Federal High Risk Pool Benefit Option only, and amends the provisions of the Certificate of Coverage to conform to the requirements of the temporary federal high risk pool program created under Section 1101 of the Patient Protection and Affordable Care Act (PPACA), administered in Maryland by MHIP.

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#### Section A- Your Contract with MHIP

1. The Section of the Certificate of Coverage entitled "**Your Contract with MHIP**" is deleted and replaced, in its entirety, with the following:

##### **Your Contract with MHIP**

The contract consists of this Certificate of Coverage, your MHIP Enrollment Application Form, and your MHIP Federal Application. Benefits are subject to change at the discretion of MHIP's Board of Directors and/or the U.S. Department of Health and Human Services (HHS). The availability and unavailability of membership in the Temporary Federal High Risk Pool Benefit Option created by the Patient Protection and Affordable Care Act and administered in Maryland by MHIP, as well as any benefits through the plan, are at all times subject to federal law, regulation, and the agreement between MHIP and HHS, and dependent on the continued availability of federal funding. Other than a valid revision to the Plan by MHIP or HHS that is consistent with applicable law and regulations, no other writing of any kind can modify this Certificate of Coverage or the terms and conditions of coverage and benefits. Furthermore, 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.

#### Section B- Some Important Terms to Know

2. The Section of the Certificate of Coverage entitled "**Some Important Terms to Know**" is amended by:
  - a) Adding the following to the definition of "**Benefit Option**":

\$1,500 HDP (Temporary Federal High Risk Pool)

- b) Replacing the definition of “**Covered Individual**” with the following:  
“Covered Individual” refers to you.
- c) Adding to the definition of “**Type of Coverage**” the following:  
Temporary Federal High Risk Pool – only the Subscriber is eligible; no Dependents are eligible for coverage, except that services for the delivery or care of newborn infants are covered for 31 days after the day of birth.

### **Section C- Enrollment and Coverage Information**

3. Section One, Subsection A, of the Certificate of Coverage (When Coverage Begins and Pre-Existing Condition Limitations) is deleted and replaced in its entirety with the following:
- A. When Coverage Begins
- Once your MHIP Enrollment Application Form and MHIP Federal Application have been received, reviewed and accepted by the Plan, the Effective Date of your coverage under the Plan will be determined as follows:
- If the Plan received your completed MHIP Enrollment Application Form and MHIP Federal Application on or before the fifteenth (15<sup>th</sup>) day of the month, your Effective Date will be the first day of the next month;
  - If the Plan received your completed MHIP Enrollment Application Form and MHIP Federal Application after the fifteenth (15<sup>th</sup>) day of the month, your Effective Date will be the first day of the month after the next month.
- For example: if the Plan receives your completed MHIP Enrollment Application Form and MHIP Federal Application on August 14<sup>th</sup> and you are approved for coverage, your coverage will be effective on September 1<sup>st</sup>. If the Plan receives your completed MHIP Enrollment Application Form and MHIP Federal Application on August 20<sup>th</sup> and you are approved for coverage, your coverage will be effective on October 1<sup>st</sup>.*
4. Section One, Subsection B (MHIP+), of the Certificate of Coverage is deleted in its entirety.
5. Section One, Subsection C (Your Premium) is amended as follows:
- a) The subsection entitled “Calculation of Your Premium” is deleted and replaced with the following:
- The Temporary Federal High Risk Pool Benefit Option Premium rate is calculated in a manner consistent with §1101(c)(2)(C)(iii) of PPACA, which mandates that the Premium be the standard rate for a standard population. This is generally determined by considering the Premium charged by health insurers offering individual coverage in the market served. The calculation of your Premium is also affected by your age.

- b) The section entitled "Payment of Your Premium" is amended by replacing the mailing address with the following address:

**Maryland Health Insurance Plan – FHRP  
P. O. Box 791023  
Baltimore, MD 21279-1023**

6. Section One, Subsection D (Coverage Changes), of the Certificate of Coverage is deleted in its entirety.

7. Section One, Subsection E (When Coverage Ends), is amended as follows:

- a) The subsection entitled "Voluntary Termination of Coverage" is replaced with the following:

***Voluntary Termination of Coverage***

You may cancel MHIP coverage 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.

- b) The subsection entitled "Termination of Coverage for Fraud or Misrepresentation" is replaced with the following:

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

You coverage under the Plan will end if:

- You perform an act or practice that constitutes fraud; or
- You made an intentional misrepresentation of material fact in your MHIP Enrollment Application Form, your MHIP Federal 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 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.

- c) The subsection entitled "Termination of Coverage for Non-Eligibility (Eligible for Substantially Similar Coverage)" is replaced with the following:

### ***Termination of Coverage for Loss of Eligibility Due to Becoming Eligible for Substantially Similar Coverage***

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

- 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 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 Subscriber 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.

- d) The subsection entitled "Termination of Coverage for Non-Eligibility" is replaced with the following:

***Termination of Coverage for Loss of Eligibility for All Other Reasons***

Coverage for you 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 Subscriber to complete a residency questionnaire at any time. On a regular basis, the Plan Administrator will review your physical address. Any Subscriber with a physical address outside the State of Maryland may be asked to complete a residency questionnaire and provide documentation of Maryland residency.

If your coverage terminates for non-eligibility, coverage will end for you 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 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.

- e) The subsection entitled "New Application for Coverage" is replaced with the following:

**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 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 six (6) months of your termination date.

**Section D- How the Plan Works**

8. Section Two, Subsection A (Types of Coverage) of the Certificate of Coverage is deleted and replaced in its entirety with the following:

Once you qualify for coverage under the Plan you may enroll yourself, as a Subscriber. Only you, as a Subscriber, can enroll. Dependents are not eligible for coverage, except that services for the delivery or care of newborn infants are covered for 31 days following the day of birth.

9. Section Two, Subsection B (Benefit Options) is amended to add the following:

***The Temporary Federal High Risk Pool Benefit Option***

Temporary Federal High Risk Pool Benefit Option Subscribers may seek Covered Services from any Preferred Provider who participates in the CareFirst BlueCross BlueShield Preferred Provider network. The Allowed Benefit for the Covered Services will be provided at the in-network Coinsurance rate. Subscribers may also seek services from any Non-Preferred Provider and the Allowed Benefit for the Covered Services will be provided at the out-of-network Coinsurance level.

Temporary Federal High Risk Pool Benefit Option Subscribers can move between in-network Preferred Providers or out-of-network Non-Preferred Providers at will and do not need to obtain a referral. However, the Plan Administrator encourages each Subscriber to establish a relationship with a principal Health Care Provider who understands your medical condition and can help you coordinate care if necessary.

Temporary Federal High Risk Pool Benefit Option Subscribers must pay an annual Deductible of \$1,500. Both medical and pharmacy claims count toward the Deductible. The Deductible applies whether services are provided by a Preferred Provider or a Non-Preferred Provider. Deductibles are discussed in detail in Section Three of this Certificate. After the Deductible is met, the Plan will pay the Allowed Benefit for most Medically Necessary Covered Services. Your Deductible is also your annual out of pocket maximum expense.

You may be able to take advantage of certain tax law reforms relating to health plans. Federal law enacted in December 2003 authorized Health Savings Accounts (HSAs), which receive favorable tax treatment by the federal government and can be used to pay for certain medical expenses of individuals enrolled in high deductible health plans. The Temporary Federal High Risk Pool Benefit Option is designed to meet Internal Revenue Service (IRS) guidelines, so that individuals who enroll in the MHIP HDP can also choose to establish an HSA to pay for certain medical and Prescription Drug out-of-pocket expenses not covered by the Plan, as permitted by the IRS.

You may wish to consult an insurance, financial or tax advisor if you want advice concerning an HSA. For information about HSAs visit the United States Department of Treasury website at <http://www.treas.gov/offices/public-affairs/hsa>.

10. Section Two, Subsections C (Provider Information), H (Covered Services Requiring Prior Authorization), and L (Filing a Claim) of the Certificate of Coverage, are amended to include the Temporary Federal High Risk Pool benefit Option under the same terms as the HDP Benefit Option.

**Section E- Covered Services**

11. Section Three, Subsection A (Plan Year Deductibles, Out-of-Pocket Maximums, Prescription Drug Annual Maximum and Lifetime Maximum) of the Certificate of Coverage is deleted and replaced in its entirety by the following:

***Plan Year Deductibles and Out-of-Pocket Maximums***

***How It Works***

Except where expressly stated in this Certificate, you must meet a Deductible each Plan Year

(July 1 through June 30<sup>th</sup>) before the Plan pays for Covered Services. The 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. A new Subscriber who joins the Plan part way through the Plan Year must still pay the full annual Deductible amount before the Plan begins to pay for Covered Services.

**Deductibles**

Under the Temporary Federal High Risk Pool Benefit Option, the Deductible is a \$1,500 combined amount. All costs incurred for Covered Services count toward the single Deductible, unless otherwise indicated, as follows:

**The following costs or payments do not count against the Deductible:**

- The portion of any Provider charge for a Covered Service that is in excess of the Allowed Benefit;
- Expenses for services that are not Covered Services;
- 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.

The Deductible is \$1,500.

Annual Deductible (includes both medical and Prescription Drug costs)	\$1,500
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Copayments for Emergency Services and Urgent Care contribute toward the Deductible.

**Out-of-Pocket Maximum**

The annual Out-of-Pocket Maximum is the most you will pay in the form of Coinsurance, Deductibles, or Copayments for your share of medical benefits during a Plan Year. Under the Temporary Federal High Risk Pool Benefit Option, once you meet your Deductible, you will also have met your Out-of-Pocket Maximum.

12. Section Three, Subsection B (Schedule of Benefits) of the Certificate of Coverage is amended as follows:

**All benefit tables contained in Section Three, Covered Services, Subsection B, Schedule of Benefits, are replaced with the following as to each service or treatment category indicated; all other text in this Subsection is unchanged and unaffected by this Endorsement, and all terms and conditions, exclusions, and limitations remain in force, including any Prior Authorization requirements:**

**Allergy Services**

	<b>Temporary Federal High Risk Pool Benefit Option (In- and Out-of-Network)</b>
Provider Office Visits	0% of the Allowed Benefit once Deductible has been met
Allergy Testing	0% of the Allowed Benefit once Deductible has been met

Allergy Injections	0% of the Allowed Benefit once Deductible has been met
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**Ambulance Transport (Non-Emergency)**

<b>Ambulance Transport (Non-Emergency)</b>	<b>Temporary Federal High Risk Pool Benefit Option (In- and Out-of-Network)</b>
Ground and Air Ambulance Transport	0% of the Allowed Benefit once Deductible has been met

**Blood & Blood Products**

	<b>Temporary Federal High Risk Pool Benefit Option (In- and Out-of-Network)</b>
Blood and Blood Products	0% of the Allowed Benefit once Deductible has been met

**Chemotherapy/Radiation Therapy**

<b>Chemotherapy/Radiation Therapy</b>	<b>Temporary Federal High Risk Pool Benefit Option (In- and Out-of-Network)</b>
Provider Office Visits	0% of the Allowed Benefit once Deductible has been met
Inpatient Hospital (Prior Authorization required)	0% of the Allowed Benefit once Deductible has been met

**Controlled Clinical Trials**

<b>Controlled Clinical Trials</b>	<b>Temporary Federal High Risk Pool Benefit Option (In- and Out-of-Network)</b>
Provider Office Visits	0% of the Allowed Benefit once Deductible has been met
Inpatient Hospital (Prior Authorization required)	0% of the Allowed Benefit once Deductible has been met
Outpatient Surgery Facility Services	0% of the Allowed Benefit once Deductible has been met

**Cosmetic and Reconstructive Surgery**

<b>Covered Cosmetic and Reconstructive Services</b>	<b>Temporary Federal High Risk Pool Benefit Option (In- and Out-of-Network)</b>
Provider Office Visits	0% of the Allowed Benefit once Deductible has been met
Inpatient Hospital (Prior Authorization required)	0% of the Allowed Benefit once Deductible has been met
Outpatient Surgery Facility Services	0% of the Allowed Benefit once Deductible has been met

**Dental Trauma**

<b>Dental Trauma Service for Injury to Sound and Natural Teeth or for the Removal of Tumors or Cysts, including General anesthesia for certain children</b>	<b>Temporary Federal High Risk Pool Benefit Option (In- and Out-of-Network)</b>
Provider Office Visits	0% of the Allowed Benefit once Deductible has been met
Inpatient Hospital (Prior Authorization required)	0% of the Allowed Benefit once Deductible has been met
Outpatient Surgery Facility Services	0% of the Allowed Benefit once Deductible has been met

**Diabetic Equipment and Services**

<b>Covered Cosmetic and Reconstructive Services</b>	<b>Temporary Federal High Risk Pool Benefit Option (In- and Out-of-Network)</b>
Provider Office Visits	0% of the Allowed Benefit once Deductible has been met
Eye Care <i>Dilated eye exam (1 per Plan Year for diabetic Subscribers)</i>	0% of the Allowed Benefit once Deductible has been met
Patient Education	0% of the Allowed Benefit once Deductible has been met
Podiatrist	0% of the Allowed Benefit once Deductible has been met
Prescription Drugs and Insulin	See the Prescription Drug Benefit
Diabetic Equipment	0% of the Allowed Benefit once Deductible has been met

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

	<b>Temporary Federal High Risk Pool Benefit Option (In- and Out-of-Network)</b>
Outpatient Dialysis Services or Home Dialysis	0% of the Allowed Benefit once Deductible has been met

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

<b>Durable and Non-Durable Supplies</b>	<b>Temporary Federal High Risk Pool Benefit Option (In- and Out-of-Network)</b>
Durable Medical Equipment	0% of the Allowed Benefit once Deductible has been met
Disposable Medical Supplies	0% of the Allowed Benefit once Deductible has been met

**Emergency Services and Urgent Care**

<b>Emergency Services</b>	<b>Temporary Federal High Risk Pool Benefit Option (In- and Out-of-Network)</b>
Care for a Medical Emergency Provided in a Hospital Emergency room (ER) (with no admission to Hospital)	\$75 Copayment prior to meeting the Deductible  0% of the Allowed Benefit once Deductible has been met
Care for a Medical Emergency Provided in a Hospital Emergency room (ER) (with admission to Hospital)	Copayment waived prior to meeting the Deductible  0% of the Allowed Benefit once Deductible has been met
<b>Urgent Care</b>	
Urgent Care Center/Facility	\$35 Copayment prior to meeting the Deductible  0% of the Allowed Benefit once Deductible has been met

**Family Planning Services**

<b>Family Planning Services</b>	<b>Temporary Federal High Risk Pool Benefit Option (In- and Out-of-Network)</b>
Provider Office Visit	0% of the Allowed Benefit once Deductible has been met
Sterilization  Inpatient (Prior Authorization required)  Outpatient Surgery Facility Services  Provider Office	0% of the Allowed Benefit once Deductible has been met

**Habilitative Care**

<b>Habilitative Services</b>	<b>Temporary Federal High Risk Pool Benefit Option (In- and Out-of-Network)</b>
Provider Office Visit	0% of the Allowed Benefit once Deductible has been met
Inpatient Hospital (Prior Authorization required)	0% of the Allowed Benefit once Deductible has been met
Outpatient Surgery Facility Services	0% of the Allowed Benefit once Deductible has been met
Physical, speech, or occupational therapy (30 visits per diagnosis per Plan Year)	0% of the Allowed Benefit once Deductible has been met

**Hearing Aids for Minor Children**

<b>Hearing Aids for Minor Children</b>	<b>Temporary Federal High Risk Pool Benefit Option (In- and Out-of-Network)</b>
Hearing Aids per Hearing Impaired Ear (Maximum of \$1,400 per ear every 36 months ONLY for Children through 18 years of age)	0% of the Allowed Benefit once Deductible has been met
Related Professional Services	0% of the Allowed Benefit once Deductible has been met

**Home Health Care**

	<b>Temporary Federal High Risk Pool Benefit Option (In- and Out-of-Network)</b>
Home Health Care	0% of the Allowed Benefit once Deductible has been met

**Hospice Care**

<b>Hospice</b>	<b>Temporary Federal High Risk Pool Benefit Option (In- and Out-of-Network)</b>
Inpatient Hospice Services (Prior Authorization required)	0% of the Allowed Benefit once Deductible has been met
Outpatient Hospice Services	0% of the Allowed Benefit once Deductible has been met

### Hospital Inpatient Services

Inpatient Hospital Services	Temporary Federal High Risk Pool Benefit Option (In- and Out-of-Network)
Inpatient Hospital Services (Prior Authorization required)	0% of the Allowed Benefit once Deductible has been met

### Infertility Testing and Diagnosis

Infertility Testing and Diagnosis Services	Temporary Federal High Risk Pool Benefit Option (In- and Out-of-Network)
Provider Office Visit	0% of the Allowed Benefit once Deductible has been met
Outpatient Surgery Facility Services	0% of the Allowed Benefit once Deductible has been met

### Maternity Care

Maternity Services	Temporary Federal High Risk Pool Benefit Option (In- and Out-of-Network)
Provider Office Visits during pregnancy	0% of the Allowed Benefit once Deductible has been met
Inpatient Hospital (Prior Authorization required)	0% of the Allowed Benefit once Deductible has been met
Abortion	Not a Covered Service – See Exclusions

### Mental Health and Substance Abuse Services

Mental Health and Substance Abuse	Temporary Federal High Risk Pool Benefit Option (In- and Out-of-Network)
Inpatient Psychiatric, Residential Treatment/Crisis Center or Partial Hospital (Maximum of 60 days per Plan Year (Prior Authorization required)	0% of the Allowed Benefit once Deductible has been met
Individual Psychiatric Sessions, Intensive Outpatient or Treatment Sessions Group Sessions	0% of the Allowed Benefit once Deductible has been met
Medication Management	0% of the Allowed Benefit once Deductible has been met

<b>Substance Abuse</b>	0% of the Allowed Benefit once Deductible has been met
Inpatient Substance Abuse Rehabilitation or Partial Hospital <i>(Maximum of 60 days per Plan Year)</i> (Prior Authorization required)	0% of the Allowed Benefit once Deductible has been met
Inpatient Substance Abuse Detoxification/Withdrawal <i>(Not Limited)</i> (Prior Authorization required)	0% of the Allowed Benefit once Deductible has been met
Individual Substance Abuse Sessions, Intensive Outpatient Treatment Sessions, Group Sessions, or Substance Abuse Intensive Outpatient Rehabilitation (IOP)	0% of the Allowed Benefit once Deductible has been met
Medication Management	0% of the Allowed Benefit once Deductible has been met

**Oral Surgery**

<b>Oral Surgery</b>	<b>Temporary Federal High Risk Pool Benefit Option (In- and Out-of-Network)</b>
Physician Office Visit	0% of the Allowed Benefit once Deductible has been met
Inpatient Hospital (with Prior Authorization)	0% of the Allowed Benefit once Deductible has been met
Outpatient Surgery Facility Services	0% of the Allowed Benefit once Deductible has been met

**Organ and Tissue Transplants**

<b>Organ and Tissue Transplants</b>	<b>Temporary Federal High Risk Pool Benefit Option (In- and Out-of-Network)</b>
Provider Office Visit	0% of the Allowed Benefit once Deductible has been met
Inpatient Hospital (with Prior Authorization)	0% of the Allowed Benefit once Deductible has been met

**Orthotics**

	<b>Temporary Federal High Risk Pool Benefit Option (In- and Out-of-Network)</b>
Orthotics	0% of the Allowed Benefit once Deductible has been met

**Outpatient Services**

<b>Outpatient Services</b>	<b>Temporary Federal High Risk Pool Benefit Option (In- and Out-of-Network)</b>
Laboratory Services	0% of the Allowed Benefit once Deductible has been met
Radiology Services	0% of the Allowed Benefit once Deductible has been met
Outpatient Surgery Facility Services	0% of the Allowed Benefit once Deductible has been met

**Physician Services**

<b>Physician Services</b>	<b>Temporary Federal High Risk Pool Benefit Option (In- and Out-of-Network)</b>
Office Visits	0% of the Allowed Benefit once Deductible has been met
Professional fees associated with: <ul style="list-style-type: none"> <li>▪ Inpatient Hospitalization</li> </ul>	0% of the Allowed Benefit once Deductible has been met
Professional fees associated with: Outpatient Surgical Services	0% of the Allowed Benefit once Deductible has been met
Emergency Room or Urgent Care physician services when performed in a licensed ER or Urgent Care Facility*	0% of the Allowed Benefit once Deductible has been met

**Prescription Drugs**

<b>Prescription Drugs</b>	<b>Temporary Federal High Risk Pool Benefit Option (In- and Out-of-Network)</b>
<b>Retail (31 day supply)</b>	
Rx Tier 1 – Generic Drug	0% of the Allowed Benefit once Deductible has been met

Rx Tier 2- Preferred Brand Name Drug	0% of the Allowed Benefit once Deductible has been met
Rx Tier 3 - Non-Preferred Brand Name Drug	0% of the Allowed Benefit once Deductible has been met
Rx Tier 4-Specialty Prescription Drugs	0% of the Allowed Benefit once Deductible has been met
<b>Specialty Injectibles (Up to one month supply)</b>	
Rx Tier 1 – Generic Drug	0% of the Allowed Benefit once Deductible has been met
Rx Tier 2 – Preferred Brand Name Drug	0% of the Allowed Benefit once Deductible has been met
Rx Tier 3 – Non-Preferred Brand Name Drug	0% of the Allowed Benefit once Deductible has been met
Rx Tier 4-Specialty Prescription Drugs	0% of the Allowed Benefit once Deductible has been met
<b>Maintenance Medications Retail or Mail Order (Up to a 90-day supply)</b>	
Rx Tier 1 – Generic Drug	0% of the Allowed Benefit once Deductible has been met
Rx Tier 2 - Preferred Brand Name Drug	0% of the Allowed Benefit once Deductible has been met
Rx Tier 3 - Non-Preferred Brand Name Drug	0% of the Allowed Benefit once Deductible has been met
Rx Tier 4-Specialty Prescription Drugs	0% of the Allowed Benefit once Deductible has been met

**Preventive Services**

Preventive Services	Temporary Federal High Risk Pool Benefit Option (In- and Out-of-Network)
Annual Physical Examination (including immunizations) <i>(1 per Plan Year)*</i>	0% of the Allowed Benefit
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>	0% of the Allowed Benefit
Abdominal Aortic Aneurysm Screening <i>(One-time screening by ultrasonography of men aged 65 to 75 who have smoked)</i>	0% of the Allowed Benefit
Alcohol Misuse Screening <i>(Coverage limited to an initial screening provided by a Primary Care Provider in connection with an annual physical examination).</i>	0% of the Allowed Benefit
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> <i>Coverage limited to behavioral education provided by a Primary Care Provider in connection with an annual physical examination.</i>	0% of the Allowed Benefit
Breast Cancer Chemoprevention Screening <i>(To identify women at high risk of breast cancer and low risk for adverse effects of chemoprevention).</i>	0% of the Allowed Benefit
Cervical Cancer Screening (e.g. pap smear) <i>(1 per Plan Year)</i>	0% of the Allowed Benefit
Chlamydia Screening Test	0% of the Allowed Benefit
Colorectal Screening <i>(Men and Women age 40 years and older)</i> <ul style="list-style-type: none"> <li>▪ <i>Digital rectal exam (1 per Plan Year)</i></li> </ul> <i>(Men and Women age 50 years and over)</i> <ul style="list-style-type: none"> <li>▪ <i>Fecal occult blood test (1 per</i></li> </ul>	0% of the Allowed Benefit

Preventive Services	Temporary Federal High Risk Pool Benefit Option (In- and Out-of-Network)
<i>Plan Year</i> <ul style="list-style-type: none"> <li>▪ <i>Flexible Sigmoidoscopy every 5 years</i></li> <li>▪ <i>Colonoscopy every 10 years</i></li> </ul> <i>Double contrast barium enema every 5 years</i>	
Depression Screening <i>(Provided in connection with an annual physical examination by a Primary Care Provider only)</i>	0% of the Allowed Benefit
Diabetes Mellitus (Type 2) Screening for Adults <i>(For adults with hypertension or hyperlipidemia)</i>	0% of the Allowed Benefit
Genetic Risk Assessment and BCRA Mutation testing for Breast and Ovarian Cancer Susceptibility <i>(For women whose family history is associated with an increased risk for deleterious mutations in the BRCA1 or BRCA2 genes)</i>	0% of the Allowed Benefit
Gonorrhea Screening <i>(For sexually active women, including pregnant women 25 and younger, or those adults or adolescents at increased risk of infection)</i>	0% of the Allowed Benefit
High Blood Pressure Screening	0% of the Allowed Benefit
HIV Screening <i>(For all adolescents and adults at increased risk for HIV infection and all pregnant women)</i>	0% of the Allowed Benefit
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>	0% of the Allowed Benefit
Mammogram Screening <i>(At intervals determined to be appropriate by your Health Care Provider.)</i>	0% of the Allowed Benefit

Preventive Services	Temporary Federal High Risk Pool Benefit Option (In- and Out-of-Network)
Obesity Screening in Adults <b>NOTE:</b> Coverage limited to screening provided by a Primary Care Provider in a primary care setting.	0% of the Allowed Benefit
Osteoporosis Screening <ul style="list-style-type: none"> <li>▪ Bone Mass Measurement 2 per Plan Year without Prior Authorization for Men and Women age 40 and above</li> </ul>	0% of the Allowed Benefit
Prostate Cancer Screening <ul style="list-style-type: none"> <li>▪ Digital rectal exam for men (1 per Plan Year for Men 40 and above)</li> <li>▪ PSA Screening for men (1 per Plan Year)</li> <li>▪</li> </ul>	0% of the Allowed Benefit
Syphilis Infection Screening <i>(For persons at increased risk and all pregnant women)</i>	0% of the Allowed Benefit
Well Child Evaluation with Immunization(s) <ul style="list-style-type: none"> <li>▪ Children over 24 months - 13 years</li> </ul>	0% of the Allowed Benefit
Well Child Evaluation with Immunization(s) <ul style="list-style-type: none"> <li>▪ Children older than 13 years of age</li> </ul>	0% of the Allowed Benefit
Well Child Examination Only <i>Children 0 -24 months</i>	\$10 Copayment prior to meeting the Deductible  0% of the Allowed Benefit
Well Child Examination Only <i>Children over 24 months</i>	0% of the Allowed Benefit
Well Child Examination with Immunization  <i>Children over 24 months through 13 years of age</i>	\$10 Copayment prior to meeting the Deductible  0% of the Allowed Benefit
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>	0% of the Allowed Benefit
Prophylactic Medication for Gonorrhea <i>(for all newborns)</i>	0% of the Allowed Benefit
Sickle Cell Disease Screening <i>(for newborns at risk for sickle cell disease)</i>	0% of the Allowed Benefit

Preventive Services	Temporary Federal High Risk Pool Benefit Option (In- and Out-of-Network)
Obesity Screening in Children and Adolescents <b>NOTE:</b> Coverage limited to screening provided by a Primary Care Provider in a primary care setting.	0% of the Allowed Benefit

**Prosthetics**

Prosthetics	Temporary Federal High Risk Pool Benefit Option (In- and Out-of-Network)
	0% of the Allowed Benefit once Deductible has been met

**Rehabilitation Services (Outpatient Therapy)**

Rehabilitation Services	Temporary Federal High Risk Pool Benefit Option (In- and Out-of-Network)
Physical, speech, or occupational therapy <i>(Services limited to 30 visits for each therapy per diagnosis per Plan Year)</i>	0% of the Allowed Benefit once Deductible has been met
All other Rehabilitation Services <i>(Services limited to 30 visits for each therapy per diagnosis per Plan Year)</i>	0% of the Allowed Benefit once Deductible has been met

**Skilled Nursing Facility**

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

Skilled Nursing Facility Services	Temporary Federal High Risk Pool Benefit Option (In- and Out-of-Network)
Skilled Nursing Facility <i>(Limited to 100 days per Plan Year)</i>	0% of the Allowed Benefit once Deductible has been met

**Spinal Manipulation (Chiropractic) Services**

<b>Spinal Manipulation (Chiropractic) Services</b>	<b>Temporary Federal High Risk Pool Benefit Option (In- and Out-of-Network)</b>
Spinal Manipulation (Chiropractic) Services <i>(Limited to a maximum of 20 visits per person per Plan Year, per diagnosis)</i>	0% of the Allowed Benefit once Deductible has been met

13. Section Three, Subsections C (Prescription Drug Program), D (Mental Health and Substance Abuse Services) of the Certificate of Coverage, are amended to include the Temporary Federal High Risk Pool Benefit Option under the same terms as the HDP Benefit Option except that, in Section Three, Subsection C (Prescription Drug Program), all references to the “\$2,600 Medical Deductible” “or “\$2,600 HDP” are deleted and replaced with “\$1,500 Deductible.”

**Section F- Exclusions and Limitations**

14. Section Four- Exclusions and Limitations, of the Certificate of Coverage is amended by adding:
- 65. Abortion services, except when the life of the woman would be endangered or when the pregnancy is the result of an act of rape or incest.
  - 66. Coverage of medical services provided to individuals other than to the named insured covered by the plan. This exclusion does not apply to coverage of services provided for the delivery or care of newborns up to 31 days after birth.

**Section G- Definitions**

15. Section Six- Definitions, of the Certificate of Coverage is amended by:

- a) Deleting the following definitions in their entirety:

**Covered Individual**  
**Deductible Carryover**  
**Member**  
**Pre-Existing Condition**  
**Types of Coverage**  
**You and/or your**

- b) Adding the following definitions:

**Covered Individual** – You, the Subscriber, only.

**Member**- You, the Subscriber, only.

**Temporary Federal High Risk Pool Benefit Option**- Means the federal high risk pool program established by the United States Department of Health and Human Services pursuant to the Patient Protection and Affordable Care Act, as amended, as administered by MHIP.

**Type of Coverage-** Subscriber only. MHIP will cover only you, the Subscriber. Dependents are not eligible for coverage.

**You and/or your-** For the purposes of this Certificate of Coverage, “you” or “your” refers to you, the Subscriber, only.

- c) replacing the definition of “Medically Uninsurable Individual” with the following:

**Medically Uninsurable Individual** – An individual who is a resident of the State and who satisfies the eligibility requirements established by federal law to enroll in a national temporary high risk pool program that is:

- A. established by the Secretary of Health and Human Services;  
and
- B. administered by the Plan for the State.

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

- A. the federal Medicare program;
- B. the Maryland Medical Assistance Program;
- C. the Maryland Children’s Health Program;
- D. an employer-sponsored group health insurance plan that includes benefits comparable to Plan benefits.

#### **Section H- No Dependent Coverage Available**

16. Dependents are not eligible for coverage under the Temporary Federal High Risk Pool Benefit Option. Any reference to “Dependent” or “Dependents” in the Certificate of Coverage is hereby deleted, except to the extent the reference specifies or serves to specify that Dependents are not eligible for coverage. Services provided for the delivery or care of newborns up to 31 days after the day of birth are covered.

This Endorsement is intended to be attached to the Certificate of Coverage for Subscribers who enroll in the Temporary Federal High Risk Pool Benefit Option. This Endorsement does not change the terms of the Certificate of Coverage unless specifically stated herein.

Effective: September 1, 2010

By: MHIP Board of Directors