OFFICE OF THE COUNTY ATTORNEY

Isiah Leggett
County Executive

Leon Rodriguez
County Attorney

MEMORANDUM

TO: Phil Andrews, Chair
Public Safety Committee

VIA: Leon Rodriguez
County Attorney

FROM: Marc P. Hansen
Deputy County Attorney

DATE: September 12, 2008

RE: Bill 25-08; Ambulance Fees – Health Insurance Reimbursement – Equal Protection

Questions

Bill 25-08, Emergency Medical Services Transport Fee – Imposition, provides that a County resident is responsible for payment of the emergency medical services transport fee (ambulance fee) "only to the extent of the resident's available insurance coverage."[1] The Council has been provided with a copy of a letter from the Government Employees Health Association, Inc. (GEHA), indicating that GEHA would deny a claim for payment of the ambulance fee proposed by Bill 25-08, because GEHA "will not cover services or supplies for which no charge would be made if the covered individual had no health insurance coverage." Council staff has asked if the "insurance only provision" of Bill 25-08 provides a legal basis for health insurance carriers to deny payment of the County's proposed ambulance fee.

Bill 25-08 also provides that individuals who are not residents of Montgomery County must pay the ambulance fee without regard to insurance coverage.[2] Hence, non-residents will be responsible, in many cases, for paying a larger proportion of the ambulance fee than resident users of the ambulance service. Council staff has asked if this disparity in treatment between residents and non-residents violates the equal protection guarantees of the United States Constitution and the Maryland Declaration of Rights.

[1] § 21-23A (c) (1), lines 19-21.
[2] § 21-23A (c) (2), lines 22-24.

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Short Answers

Under the "insurance only provision" of Bill 25-08, a resident incurs no personal liability for the County's ambulance fee. Therefore, in many, if not most cases, private health insurance carriers would have a legal basis for refusing to pay a claim for payment of the ambulance fee.[3]

The Council, however, could amend Bill 25-08 to impose a fee on all ambulance users, but provide that taxes collected by the County will be deemed as payment on behalf of County residents of the uninsured portion of the ambulance fee. Amending Bill 25-08 in this manner would give Montgomery County a legal basis for insisting that health insurance carriers must pay the County's ambulance fee.

Imposing a higher ambulance fee on non-residents does not violate the equal protection guarantees of the United States Constitution or the Maryland Declaration of Rights so long as the disparate treatment rests on a reasonable rationale. By imposing a higher ambulance fee on non-residents, Bill 25-08 advances the reasonable legislative goal of more fairly distributing the cost of providing ambulance service within the County between residents who pay taxes to the County and non-residents.

Discussion

Heath Insurance – Liability for Ambulance Fee.

"Broadly speaking, health insurance is an undertaking by one person for reasons satisfactory to him to indemnify another for losses caused by illness." *Haines v. United States*, 353 U.S. 81, 83 (1957). "A medical expenses indemnity contract is an 'indemnity' contract, i.e., one which insured the subscriber against **actual** expense. On the other hand, an accident policy is not an indemnity contract and benefits may be due thereunder even though no actual **loss** has been incurred." (Emphasis in original) *Shapira v. United Medical Service, Inc., et al.*, 15 NY2d 200, 218-19 (1965).

In *Shapira*, a physician sought reimbursement for services provided to patients in a ward of a New York City municipal hospital. The court concluded that United Medical Service, Inc., a non-profit medical indemnity corporation, had no liability to the physician, because the patients treated were not liable for the services rendered—therefore, United Medical Service had no responsibility to compensate the physician.

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[3] This opinion does not address reimbursement from federal health care programs like Medicare. Federal health care programs reimburse local jurisdictions for ambulance fees even though the ambulance fee is imposed on residents only to the extent of their insurance coverage. This approval appears to be based on the rationale that local taxes may be deemed as payment on behalf of residents of the uninsured portion of an ambulance fee. In a July 20, 2001, opinion, the Office of the Inspector General for the Department of Health and Human Services concluded that a fire district's proposed ordinance that "only requires residents to pay to the extent of their insurance coverage (i.e., "insurance only" billing) and treats the operating revenues received from local taxes as payment of any otherwise applicable co-payments and deductibles due from the residents" would not violate the anti-kickback statute under federal law.

Other cases support the premise articulated in *Shapira*. In *Dillione v. Deborah Hospital, et al.*, 113 N.J. Super. 548 (1971), Alfred Dillione had open-heart surgery at the Deborah Hospital. Dillione was covered under a group health insurance policy issued by The Traveler's Insurance Company. The Traveler's Insurance Policy contained an exclusion from coverage that provided, "in no event will the employee's benefit be payable . . . for any . . . services or supplies . . . for which the employee incurred no expense." *Id* at 551. The court noted:

> Where, however, the holder of a policy covering "expense incurred" for hospital charges received free care at a United States Veterans Hospital for which by federal law the hospital could make no charge against him, the holding was that since the plaintiff was **entitled** to free treatment, he had incurred no expense and was therefore not entitled to recover on the policy. (Emphasis in original) (Citations omitted)

Id. at 554-55.

The *Dillione* court concluded that the matter had to be remanded to the trial court because there was insufficient evidence in the record to determine if Dillione was primarily liable to the hospital for services rendered, whether or not sufficient insurance proceeds were available to cover the entire expense. The court stated

> If, on the other hand, Deborah's understanding with plaintiff, or with the Rehabilitation Commission on plaintiff's [Dillione's] behalf as a donee/beneficiary, was that plaintiff was under no circumstances to be liable to Deborah, the latter being content to resort solely to such rehabilitation or insurance moneys, if any, as might be available, plaintiff would have incurred no expense and Traveler's would not be liable.

Id. at 556.

Insurance in general, and health insurance in particular, is heavily regulated by the State of Maryland. Title 15 of the Maryland Insurance Code, consisting of nearly 250 pages of legislation, is devoted exclusively to the regulation of health insurance. In the instance of health insurance plans offered to the small employer market, State law actually requires that insurance carriers include the following coverage exclusion in their plans: "Services for which a covered person is not legally, or as a customary practice, required to pay in the absence of a health benefit plan." COMAR 31.11.06.06 (2008).

A brief and somewhat random survey of individual health insurance plans offered in Maryland indicates that this exclusion required for health plans offered to small employers is commonly found in other plans. For example, one plan offered by CareFirst (Blue Cross/Blue Shield) provides, "Payment will not be made for services which, if the Member were not covered under the Group Contract, would have been provided without charge, including any charge or any portion of a charge which, by law, the provider is not permitted to bill or collect from the patient directly." Another CareFirst contract provides that payment will not be made, "for services without charge, including Medicaid, or where only insured persons are charged." Similar provisions appear in health insurance plans offered by United Healthcare and CeltiCare.[4]

Insurance carriers that include similar exclusions from coverage like that quoted from the CareFirst plan, will have a legal basis for refusing to pay Montgomery County's ambulance fee, because Bill 25-08 imposes no liability on residents for the ambulance fee. *Shapira v. United Medical Service, Inc.*

A different legal result, however, may obtain, if Bill 25-08 were amended to provide for imposition of the ambulance fee on all users but then provided that taxes collected from residents would be treated as payment of the residents' uninsured portion of the ambulance fee. If payment of taxes by resident was viewed as a collateral source of payment for the ambulance fee, a legal basis may be established for requiring private health insurance carriers to pay the County's ambulance fee on behalf of its insureds. In *Dillione v. Deborah Hospital*, the court noted

> The general rule is that the insured will not be barred from recovery on a policy providing for payment of hospital or medical services, etc., for which he has "insured expense" or similar language, by mere reason of the availability of collateral means of discharging his liability therefor so as to have relieved him of the need to pay the charges personally.

Id. at 554.

Columbus, Ohio, has adopted an ordinance that imposes an ambulance fee that appears to be premised on this collateral source of payment concept noted in *Dillione*. The Columbus ordinance treats taxes collected from residents as inuring to the benefit of resident users of the ambulance service. Section 1934.03 of the Columbus, Ohio, Code provides, "There is hereby established an emergency medical services reimbursement program which is incident to the provision of emergency medical services by the Division of Fire." Section 1934.04(a) provides "The Department of Public Safety shall establish fees for emergency medical services it renders to any person, whether a resident or non-resident of the City." Subsection (d) provides, "The cost of emergency medical care for a resident of the City that are not covered by private insurance or a public health care program **shall be deemed to be paid** from the operating

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[4] See Attachment A.

revenues received by the City from local taxes and other sources." (Emphasis added)[5] According to an Assistant Columbus City attorney, private insurance carriers pay the City on behalf of their policy holders some portion of the ambulance fee imposed by the City.

Treating tax revenue as a source of prepayment of the uninsured portion of the ambulance fee incurred by a resident is comparable to the County providing each resident with a supplemental insurance policy--*i.e.* a collateral source of payment. As the *Dillione* court put it, "The mere fact . . . it was contemplated or expected that other sources would be available to defray the bill in whole or in part would not dissipate Traveler's liability for so much of the expenses plaintiff was primarily liable for." *Id.* at 556. See also, *Samsel v. Allstate Insurance Company*, 204 Ariz. 1, 59 P.3d 281 (2002) (Allstate Insurance Company required to reimburse its insured, Samsel, for hospital expenses even though the expenses had been paid by Samsel's health maintenance organization, because Allstate's insurance policy provided for payment of medical expenses "actually incurred" by its insured.) A similar result was reached by the Maryland Court of Appeals in *Dutta v. State Farm Insurance*, 363 Md. 540 (2001). In *Dutta*, the court concluded that State Farm Insurance was required to pay PIP (Personal Injury Protection) benefits to Dutta even though Dutta's hospital expenses were paid by his health maintenance organization.

Although there are no cases directly on point and so the matter is not free from doubt, amending Bill 25-08 to adopt an approach similar to the one used by Columbus would create a basis for imposing legal liability for the ambulance fee under most current private health insurance contracts. The County could reinforce the concept of tax revenues serving as a collateral source of payment for a resident's uninsured portion of the ambulance fee by annually appropriating from the general fund to the Consolidated Fire Tax District Fund an amount necessary to cover the liability for the balance of the fee owed by residents that the County estimates will not be covered by residents' insurance coverage.

Equal Protection

Bill 25-08 effectively imposes a greater burden on non-residents for the ambulance fee than is imposed on residents. Local governmental entities commonly impose higher user fees on non-residents *See*, for example, Montgomery County recreation fees ("Non-County residents must pay an additional $10 per participant, per activity."); Montgomery County Public School System tuition charge on non-residents ("All qualified school-aged individuals, whether U.S. citizens or non-citizens, who do not have an established *bona fide* residence in Montgomery County, will be considered non-resident students and will be subject to paying tuition unless an exception is made under the terms of this policy."); and Montgomery College tuition schedule, Code 3, which imposes higher tuition charges on non-residents than it imposes on resident students.[6] Nevertheless, any disparate treatment of individuals based on residency raises an equal protection issue under the United States Constitution and the Maryland Declaration of Rights.

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[5] A copy of the relevant portions of the Columbus Code are attached. See Attachment B.

[6] See Attachment C for information from the Montgomery County Department of Recreation, Montgomery County Public School System and Montgomery College.

Equal protection guarantees under the 14th Amendment of the United States Constitution and Article 24 of the Maryland Declaration of Rights are independent of each other. *Frankel v. Board of Regents of the University of Maryland System, et al.*, 361 Md. 298 (2000). Accordingly, each provision will be examined separately.

Federal courts have upheld imposing higher fees on non-residents in the face of 14th Amendment equal protection challenges. The United States Supreme Court approved Montana's imposition of a higher charge on non-residents to obtain a State elk-hunting license. *Baldwin, et al. v. Fish and Game Commission of Montana, et al.*, 436 U.S. 371 (1978). The Supreme Court noted that residents support the maintenance of big game in Montana by taxes, which support parks, game wardens, roadways, fire suppression, etc. "All this adds up, in our view, to no irrationality in the differences the Montana legislature has drawn in the costs of its licenses to hunt elk. The legislative choice was an economic means not unreasonably related to the preservation of a finite resource and a substantial regulatory interest of the State." *Id.* at 390. Although as the Court noted, the cost differential Montana imposed between resident and non-resident hunters might have been more precisely calculated, the Supreme Court nevertheless concluded, "a statutory classification impinging upon no fundamental interest . . . [that could] have furthered its underlying purpose more artfully, more directly, or more completely, does not warrant a conclusion that the method it choose was unconstitutional." *Id.* at 390.

More recently, the U.S. Court of Appeals for the First Circuit upheld the Town of Dartmouth's imposition of higher harbor fees on non-residents. *LCM Enterprises, Inc., et al., v. the Town of Dartmouth, et al.*, 14 F.3d 675 (1994). Finding that the disparate fee structure involved no suspect classification or impingement of a fundamental right, the Court applied the rational basis test to determine the constitutionality of the disparate treatment accorded non-residents:

> When a state, or political subdivision thereof, distinguishes between two similarly situated groups, the distinctions it makes are subject to scrutiny under the Equal Protection Clause of the Fourteenth Amendment. Such scrutiny is normally of the rational basis variety unless the distinction involves a suspect classification or burdens a fundamental right.
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> * * *
>
> Under rational basis scrutiny, a classification will withstand a constitutional challenge as long as it is rationally related to a legitimate state interest and is neither arbitrary, unreasonable nor irrational.

Id. at 678-79.

Dartmouth asserted that its goal in imposing a disparate fee structure based on the residency of the user was to fairly distribute harbor costs among all users, thus equalizing the burden between residents and non-residents of maintaining the harbor. The Court agreed that this goal established a rational basis justifying disparate treatment between residents and non-residents, "if the record evidences any reasonable basis for Dartmouth to believe that there was a disparity in waterways contributions between residents and nonresidents." *Id.* at 680. The record in the case showed that Dartmouth spent all of the money received from harbor fees and, in addition, spent an even greater amount from the Town's general tax revenues to maintain the harbor. The Court concluded, "There is thus a disproportionate burden on residents for harbor expenses **even after the disparate fees are imposed**. Clearly, Dartmouth's attempt to make up some of this disparity through a disparate fee structure passes constitutional muster." (Emphasis in original) *Id.* at 681.

No Maryland case has directly considered the validity of imposing greater fees on non-residents in the context of an equal protection challenge under Article 24 of the Declaration of Rights—despite the apparent wide-spread practice of local jurisdictions in Maryland imposing higher user fees on non-residents. Although not directly on point, an examination of *Frankel v. Board of Regents of the University of Maryland* is instructive in analyzing the probable outcome of an equal protection challenge of the County's proposed ambulance fee under an Article 24 challenge. In this case, Jeremy Frankel challenged the manner in which the University of Maryland determined if a person was a resident. The court noted, "As the petitioner [Frankel] does not challenge the objective of according a reduced tuition benefit to *bona fide* Maryland residents, we shall assume that the Board's objective is entirely legitimate." *Id.* at 317. The court concluded that the method used by the University to determine residency status violated Article 24 because it imposed economic burdens tending to favor some Maryland residents over other Maryland residents. Thus, the court was deeply troubled that a *bona fide* Maryland resident would be treated as a non-resident. Although the court noted that it has been "particularly distrustful of classifications" that treat "residents of one county or city differently from residents of the remainder of the state", disparate treatment will be upheld if it rests on "some ground of difference having a fair and substantial relation to the object of the regulation." *Id.* at 316-17.

The ambulance fee proposed by Bill 25-8, which assigns a greater economic burden to non-residents is intended, like the harbor fee assessed by Dartmouth, to fairly distribute the burden of providing a governmental service between residents, who pay the taxes used to support the service, and non-residents. According to the Office of Management and Budget there is no question that County residents, as taxpayers, will continue to pay a disproportionate share of the cost of providing ambulance service in Montgomery County even after imposition of an ambulance fee. The Office of Management and Budget projects that revenues from ambulance fees as a percentage of the cost of providing ambulance service in the County will, in the first year, account for 23.8% of the cost; in the second year, 25.0%; in the third year, 26.2%; and in the fourth year, 27.4%. In light of this fact, the disparate treatment between residents and non-residents in the imposition of the County's ambulance fee rests, as the Court of Appeals put it in *Frankel*, on "some ground of difference having a fair and substantial relation to the object of the regulation."

I trust the Public Safety Committee will find this memorandum helpful in its consideration of Bill 25-08. If the Committee has any questions or concerns regarding this advice, please let me know.

cc: Thomas Carr, Chief, Montgomery County Fire & Rescue Services
Joseph Beach, Director, Office of Management & Budget
Kathleen Boucher, Assistant Chief Administrative Officer
Michael Faden, Senior Legislative Counsel
Douglas Wolfberg, Special Counsel
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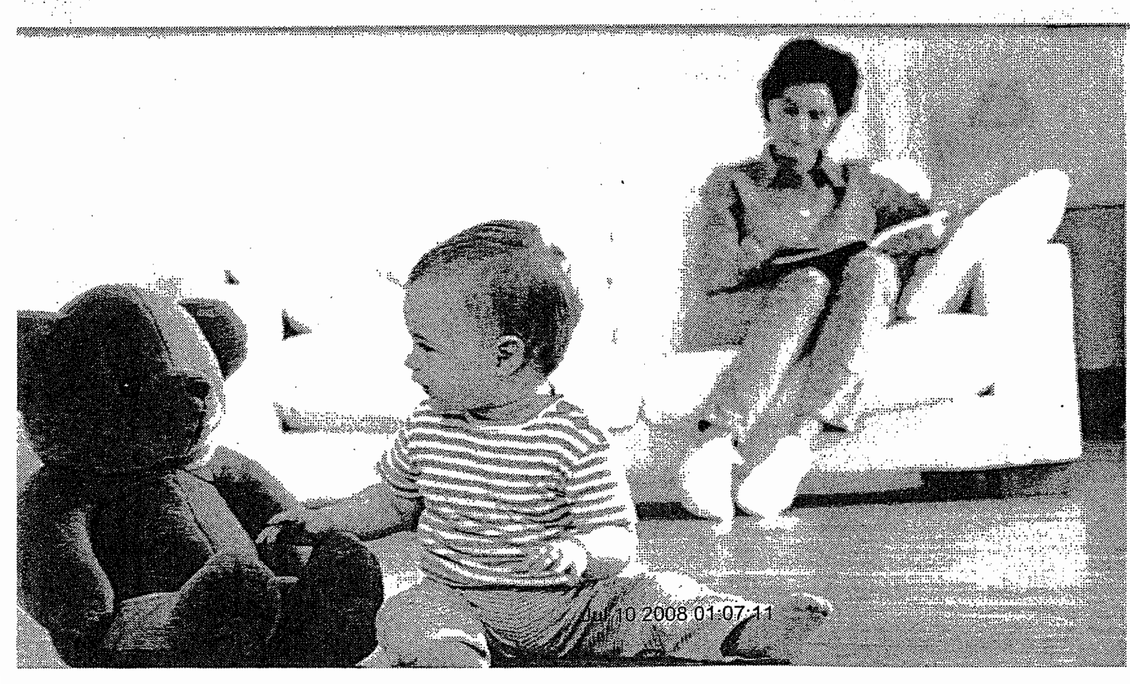

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Policy Forms C-006.3 or C-006.4
Health Insurance Available Only to Members of FACT

Attachment A

General Exclusions

No benefits are payable for expenses which:

- Are due to pregnancy (except for complications of pregnancy) or routine newborn care (unless optional coverage is selected, if available).
- Are for routine or preventive care unless provided for in the policy.
- Are incurred while confined primarily for custodial, rehabilitative, or educational care or nursing services.
- Result from or in the course of employment for wage or profit, if the covered person is insured, or is required to be insured, by workers' compensation insurance pursuant to applicable state or federal law. If you enter into a settlement that waives a covered person's right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply.
- Are in relation to, or incurred in conjunction with, investigational treatment.
- Are for dental expenses or oral surgery, eyeglasses, contacts, eye refraction, hearing aids, or any examination or fitting related to these.
- Are for modification of the physical body, including breast reduction or augmentation.
- Are incurred for cosmetic or aesthetic reasons, such as weight modification or surgical treatment of obesity.
- Would not have been charged in the absence of insurance.
- Are for eye surgery to correct nearsightedness, farsightedness, or astigmatism.
- Result from war, intentionally self-inflicted bodily harm (whether sane or insane), or participation in a felony (whether or not charged).
- Are for treatment of temporomandibular joint disorders, except as may be provided for under covered expenses.
- Are incurred for animal-to-human organ transplants, artificial or mechanical organs, procurement or transportation of the organ or tissue, or the cost of keeping a donor alive.
- Are incurred for marriage, family, or child counseling.
- Are for recreational or vocational therapy or rehabilitation.
- Are incurred for services performed by an immediate family member.
- Are not specifically provided for in the policy or incurred while your certificate is not in force.
- Are for any drug treatment or procedure that promotes conception.
- Are for any procedure that prevents conception or childbirth.
- Result from intoxication, as defined by applicable state law in the state where the illness or injury occurred, or under the influence of illegal narcotics or controlled substances unless administered or prescribed by a doctor.
- Are for or related to surrogate parenting.
- Are for or related to treatment of hyperhidrosis (excessive sweating).
- Are for fetal reduction surgery.
- Are for alternative treatments, except as specifically identified as covered expenses under the policy/certificate, including: acupressure, acupuncture, aromatherapy, hypnotism, massage therapy, rolfing, and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.

Benefits will not be paid for services or supplies that are not medically necessary to the diagnosis or treatment of an illness or injury, as defined in the policy.

General Limitations

- Expenses incurred by a covered person for treatment of tonsils, adenoids, middle ear disorders, hemorrhoids, hernia, or any disorders of the reproductive organs are not covered during the covered person's first six months of coverage under the policy. This provision will not apply if treatment is provided on an "emergency" basis. "Emergency" means a medical condition manifesting itself by acute signs or symptoms that could reasonably result in placing a person's life or limb in danger if medical attention is not provided within 24 hours.
- Covered expenses will not include more than what was determined to be the reasonable and customary charge for a service or supply.
- Transplants eligible for coverage under the Transplant Expense Benefit are limited to two transplants in a 10-year period.
- Charges for an assistant surgeon are limited to 20% of the primary surgeon's covered fee.
- Covered expenses for surgical treatment of TMJ, excluding tooth extractions, are limited to $10,000 per covered person.
- All diagnoses or treatments of mental disorders, as defined in the policy, including substance abuse, are limited to a lifetime maximum benefit of $3,000 (not covered in Saver Plans, subject to state variations). Covered expenses for outpatient diagnosis or treatment of mental disorders are further limited to $50 per visit. As with any other illness or injury, inpatient care that is primarily for educational or rehabilitative care is not covered.

The CELTICARE II Health Plan

Maryland

Comprehensive, flexible coverage

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deductible and coinsurance will apply. Drugs and medicines that are received after the first day of treatment for this bodily injury shall not be covered under this benefit.

Prescription Drug Option – Drugs with generic alternatives require the specified copay plus 100% of the cost difference between the drug and the generic alternative. Maintenance Drug prescriptions available by retail and mail order for a 90 day supply with a copay equal to 3x a one month supply.

Retail:

Generic

- No deductible
- $20 copay

Brand (Preferred and Nonpreferred/Specialty drugs)

- $100 annual deductible per person, per calendar year
- $40 copay for preferred drugs
- $75 copay for nonpreferred/specialty drugs

The following benefits are only available when a Preferred Provider Organization (PPO) plan is selected.

CELTICARE II SELECT PPO PLAN

Network Physician Office Visits – Services performed by a network physician for a symptomatic insured person in an office setting are covered, subject to a $15 per visit copayment amount, up to six visits per person, per calendar year. The office visit covers only management and evaluation services and does not include labs and x-rays.

Non-network Services – The annual deductible is increased by $1,500 and an additional 20% coinsurance applies for all services received from an out-of-network provider (physician and/or hospital). This amount does not apply to the out-of-pocket maximum. Also, the office visit copay does not apply when non-network physicians are used.

CELTICARE II "ANY DOC" PPO PLAN

Physician Office Visits – Services performed by a physician for a symptomatic insured person in an office setting are covered, subject to a $35 per visit copayment amount, up to six visits per person, per calendar year. The office visit covers only management and evaluation services and does not include labs and x-rays.

Non-network Services – The annual deductible is increased by $1,500 and an additional 20% coinsurance applies for all services received from an out-of-network hospital. This amount does not apply to the out-of-pocket maximum.

If charges by a non-network hospital are incurred by an insured person due to a medical emergency, the annual deductible and coinsurance will be the same as if provided by a network hospital.

CELTICARE II HEALTH PLAN EXCLUSIONS

Benefits are not paid under any plan for a sickness or bodily injury resulting from:

- any act of war, declared or undeclared, or service in the military forces of any country, including non-military units supporting such forces;
- suicide or attempted suicide, or self-inflicted bodily injury while sane or insane;

No benefits are paid that are provided:

- free of charge in lieu of this insurance;
- by a government-operated hospital unless the insured person is required to pay;
- for treatment received outside the United States except for a medical emergency while traveling for up to a maximum of 90 consecutive days;

Additionally, no benefits are paid for:

- sickness or bodily injury that arises out of, or as a result of, any work if the insured person is required to be covered under Worker's Compensation or similar legislation.

Other exclusions include:

- tubal ligations and vasectomies performed while hospital confined are not covered. The reversal of a tubal ligation or vasectomy is not covered at any time;
- gender reassignment (sex change or reassignment);
- eye refractions, vision therapy, glasses or fitting of glasses, contact lenses, surgical or non-surgical treatment to correct refractive eye disorders, or any treatment or procedure to correct vision loss;
- hearing aids, exams or fittings, or surgical or non-surgical treatment or procedure to correct hearing loss;
- treatment or medication that is experimental or investigational;
- custodial care;
- myringotomy or dilation and curettage and surgical treatment of tonsils, adenoids or hernia within first 6 months of coverage;
- outpatient prescription drugs, unless purchased at a participating pharmacy;

IMPORTANT PLAN INFORMATION

Eligibility Requirements – To qualify for CeltiCare II coverage, a primary applicant must be six months or over and under 64½ years of age and must not be covered under any other health insurance plan. Applicant must be a United States citizen or a foreign resident who has been living in the United States for at least two years under a permanent visa. Dependents must be 6 weeks or older.

Underwriting – Your CeltiCare II application is individually underwritten based on the health history of you and your dependents to be covered. To effectively underwrite your application, Celtic must obtain as much medical information about you as possible. This is accomplished through the use of health questions on the application form and, in some instances, a follow-up medical questionnaire and/or telephone verification of information. In addition, Celtic may request medical records as necessary. If you answered "NO" to the five health questions on the application, have acceptable occupations/avocations, and are within the Company's height, weight, and age guidelines, your agent can get coverage instantly with QuikCoverage, if available in your state. Otherwise, please mail your application for underwriting.

Credit for Prior Deductibles – If you choose to replace current insurance coverage with the CeltiCare II Health Plan, you will receive credit for satisfying any portion of the previous carrier's deductible in the same calendar year. Copies of EOBs (Explanation of Benefits) are required for proof of deductible.

PLEASE NOTE: Creditable Coverage - Time spent under the CeltiCare II Health Plan may or may not count towards "creditable coverage" as defined in the Health Insurance Portability and Accountability Act, Public Law 104-191. Your individual circumstances, as well as state and federal law, will determine how much, if any, of your coverage under the CeltiCare II Health Plan is creditable coverage.

Pre-existing Conditions – A pre-existing condition is a sickness or bodily injury for which an insured person received a diagnosis, medical advice, consultation, or treatment during the 12 months prior to the effective date, or for which an insured person had symptoms 12 months before the effective date which would cause an ordinarily prudent person to seek medical care or treatment.

CeltiCare II will provide full coverage of pre-existing medical conditions if certain specific guidelines are met. The applicant must fully disclose all pre-existing medical conditions on the application. Then, if they pass our underwriting guidelines, on a standard basis, we'll provide full coverage. Benefits are not paid for an insured person's undisclosed pre-existing condition until coverage has been in force 12 months from the effective date provided coverage was issued on a standard basis.

When Coverage Begins and Ends – Your effective date will appear on the schedule page of your Policy, provided that you mail in your premium payment with your application and are accepted for coverage.

Coverage ends when:

- you fail to make the required premium payments;
- you cease to be an eligible dependent;
- you begin living outside the United States;
- you perform an act or practice that constitutes fraud;
- you have made an intentional misrepresentation of material fact under the Policy.

Celtic's Health Care Certification Program – Health Care Certification is a benefit which is automatically included in the CeltiCare II Health Plan. The Health Care Certification Program promotes high-quality medical care, and can help you better understand and evaluate your treatment options.

How does it work? – You need to contact the Celtic Health Care Certification Program at 1-800-477-7870 to certify medical treatment. The review team is made up of medical advisors with backgrounds in the medical, surgical, and psychiatric fields. If you have concerns about your proposed treatment, they can help you develop appropriate questions to ask your physician. The medical advisor may also discuss possible alternatives with your doctor if there are any questions regarding the necessity of your treatment. Celtic recommended second surgical opinions are always paid at 100%. Also, in the event of a non-certification there is an appeal process available.

Remember, the final decision for medical treatment is always the right and responsibility of you and your doctor.

What if I don't notify Celtic before treatment? – For all plans non-notification results in an exclusion from eligible expenses of 20% of all charges related to the treatment, if you did not notify the Celtic Health Care Certification Program before treatment.

What if my treatment is considered not medically appropriate and/or not medically necessary? – A "Notice of Non-Certification" is issued to you and your doctor. If you decide to receive the non-certified treatment, no benefits are paid.

IMPORTANT NOTE

The information shown in this brochure and in any accompanying literature is not intended to provide full details of Celtic plans and may change at the discretion of Celtic Insurance Company. Complete terms of coverage are outlined in the individual Policy Booklets. In applying for coverage, the primary insured agrees to be bound by the Policy.

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Colombus, Ohio

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Title 19 POLICE AND FIRE DIVISIONS CODE

Chapter 1934 EMS REIMBURSEMENT FOR EMERGENCY MEDICAL SERVICES.

1934.01 Designation as primary provider.

1934.02 Minimum level of care.

1934.03 Program established.

1934.04 Fees.

1934.05 Disposition of moneys.

1934.01 Designation as primary provider.

The division of fire is the primary provider of pre-hospital emergency medical services within the corporate limits of the city and may provide such services outside the corporate limits of the city. All persons in need of such services are entitled to receive them without prior determination of their ability to pay. No person requiring emergency medical services shall be denied services due to lack of insurance or ability to pay. (Ord. 1183-02 § 1 (part).)

1934.02 Minimum level of care.

The city hereby mandates that all emergency medical service requests arising within the city through the 911 system or through any other means that an emergency call is received, be provided at the Advanced Life Support (ALS) level. (Ord. 1183-02 § 1 (part).)

1934.03 Program established.

There is hereby established an emergency medical services reimbursement program which is incident to the provision of emergency medical services by the division of fire. All policies governing this program shall be determined by the director of the department of public safety in collaboration with the director of the department of finance and management. (Ord. 1183-02 § 1 (part).)

1934.04 Fees.

(a) The department of public safety shall establish fees for emergency medical services it renders to any person, whether a resident or nonresident of the city. The fee shall reflect the costs of providing services for emergency care and shall include the costs of medical care plus the costs associated with transportation. Such fees, and any revisions to the fees, shall be approved by the director of the department of finance and management.
(b) When the division of fire renders emergency medical services to individuals, it shall inquire whether such individual is covered by any private or public health insurance plan, and, if the resident has coverage, the division shall attempt to make further inquiry to obtain the minimum data required to maintain accurate records and submit bills to the insurance carrier or public health care program, or to the patient's financially responsible party when required by law.
(c) The department of public safety is hereby authorized to enter into a contract with a third party

billing agency for the performance of emergency medical services billing and collection services. The department, or the authorized contractor, shall bill for such services within the timeframes established by department policy or by contract with a third party billing agency.
(d) The department of public safety, or the authorized contractor, shall collect from nonresidents of the city, those costs of emergency medical care that are not covered by their insurance carrier or public health care program. Such costs are limited to the insured's co-payment and/or coinsurance amounts as provided in the insured's coverage policy. The city will not balance bill when prohibited by law. In the event that a nonresident is uninsured, the department of public safety, or its designee, shall bill the nonresident for the full cost of services provided. The department may establish a hardship waiver determination policy to consider waiving the out-of-pocket financial obligations of nonresidents demonstrating a bona fide inability to pay. The costs of emergency medical care for a resident of the city that are not covered by private insurance or a public health care program shall be deemed to be paid from the operating revenues received by the city from local taxes and other sources.
(e) The department of public safety, or the authorized contractor, shall make reasonable efforts to collect amounts due from nonresidents of the city for the non-covered costs of care as outlined in subsection (d). (Ord. 1183-02 § 1 (part); Ord. 1102-05 § 1 (part).)

1934.05 Disposition of moneys.

All fees so collected by the department of public safety, or the authorized contractor, shall be deposited into the general fund. (Ord. 1183-02 § 1 (part).)

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MONTGOMERY COUNTY MARYLAND
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RECREATION DEPARTMENT

Programs Go!

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240-777-6840

Registration Information

Five Ways to Register

1 RecWeb Online registration is available for most classes listed in the Recreation Guide. Internet users must pay their account in full. For additional information, call 240-777-6840 or click here for an online tour.

2 STARline members may register by using our telephone automated registration system. If you are interested in becoming a STARline member, please fill in the application form. Allow two weeks for your STARline application to be processed. STARline users must pay their account in full. STARline registration number is 240-777-8277.

3 **Fax 240-777-6818** Faxed registrations must be paid by VISA or MasterCard. Due to high volume, we are unable to confirm receipt of faxes. To avoid duplication, do not mail your original form.

4 **Mail** Montgomery County Dept. of Recreation, Attention: Registrar, 4010 Randolph Road, Silver Spring, MD 20902-1099.

5 **Full Service** in-person registration is available at the following locations:

Administrative Offices 240-777-6840
4010 Randolph Road, Silver Spring
M-F 8:30am-5:00pm

Registration is also available at all Regional Service Centers.

Bethesda-Chevy Chase 301-983-4467
11315 Falls Road, Potomac

East County 240-777-4980
14906 Old Columbia Pike, Burtonsville

Mid-County 240-777-4930
4010 Randolph Road, Silver Spring

Silver Spring 240-777-4900
2450 Lyttonsville Road, Silver Spring

Upcounty 240-777-6940
12900 Middlebrook Road, Germantown

Registration Confirmation

Confirmations will be mailed as registrations are processed. If you do not receive your confirmation, call 240-777-6840. A waiting list notification will be sent to you if you do not get placed.

Attachment C

Payment Information

1 Full payment must be made at time of registration. Do not submit registrations and/or payments to the instructor at the program. See Five Ways to Register.

2 Non-county residents must pay an additional $10.00 per participant per activity.

3 Make checks and money orders payable to MCRD. Checks and money orders must include name, address, home and work telephone numbers, driver's license number, and participant's full name. VISA or MasterCard payments are accepted. Registration form must include correct credit card number, expiration date, authorized signature, and authorized amount.

4 Financial Assistance is available to county residents who are recipients of assistance from other Montgomery County agencies. Eligibility is based on proof of that assistance. A financial assistance application form may be picked up at any recreation office, community center, or swim center. You may also obtain an application by calling 240-777-6840; or through the internet.

5 Payment plans are offered only for summer programs to county residents who cannot pay the full amount due at the time of registration. All payment plans must be paid in full by June 1. Please register early to take advantage of this payment option.

6 The Department of Recreation reserves the right to pursue all available options to collect any funds owed as the result of a dishonored check or credit card, charges incurred due to unsubstantiated credit card disputes, or any outstanding debt.

If your check is returned unpaid, your account will be debited electronically for the original check amount and electronically or via paper for the state's maximum allowable service fee. Payment by check constitutes authorization of these transactions. You may revoke your authorization by calling 800-666-5222 ext. 2 to arrange payment due for any outstanding checks and service fees due.

Withdrawal Policy

Registration form

Cancellation Policy

Administrative Office: 4010 Randolph Road, Silver Spring, MD 20902
Customer Service: Monday-Friday: 8:30am-5:00pm

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POLICY BOARD OF EDUCATION OF MONTGOMERY COUNTY

Related Entries: JEA-RB, JEA-RC, JEA-RD, JED-RA, JEE, JEE-RA, KLA-RA
Responsible Office: Chief of Staff

Residency, Tuition, and Enrollment

A. PURPOSE

The Board of Education is committed to an effective, efficient, and equitable enrollment process for all eligible Montgomery County school-aged children.

B. ISSUE

All qualified school-aged individuals, whether U.S. citizens or noncitizens, who have an established bona fide residence in Montgomery County are to be admitted free to the Montgomery County Public Schools. There are circumstances that exist where students who are not residents of Montgomery County want or need to attend schools here; therefore, issues of residency and the processes for paying tuition must be clearly articulated.

C. POSITION

The Board of Education of Montgomery County supports the right of its residents to a free public education.

1. Bona fide residence is one's principal residence, maintained in good faith, and does not include a residence established for convenience or for the purpose of free school attendance in the Montgomery County Public Schools. However, an intent to reside indefinitely or permanently at the present place of residence is not necessarily required. Determination of a person's bona fide residence is a factual one and must be made on an individual basis.

2. All qualified school-aged individuals, whether U.S. citizens or noncitizens, who have an established bona fide residence in Montgomery County will be considered resident students and will be admitted free to the Montgomery County Public Schools.

3. All qualified school-aged individuals, whether U.S. citizens or noncitizens, who do not have an established bona fide residence in Montgomery County, will be

considered nonresident students and will be subject to paying tuition unless an exception is made under the terms of this policy.

a) A qualified student placed in a group home or foster home located in Montgomery County by an out-of-state agency other than those specified in Section 4-122 of the Education Article, *Annotated Code of Maryland*, shall be presumed to be a nonresident student.

b) In the absence of evidence to the contrary, a qualified student who is a resident of another educational jurisdiction, but who elects to seek enrollment in a Montgomery County public school shall be presumed to be a nonresident student.

c) In the absence of evidence to the contrary, the bona fide residence of a qualified student who is under 18 years of age and not emancipated shall be presumed to be the bona fide residence of both or one of the child's parents. Throughout this policy and any implementing regulations, if the parents live apart, use of the word "parent" shall mean (1) the parent to whom legal custody is awarded or (2) if legal custody is not awarded, the parent with whom the child regularly lives; and the child's bona fide residence shall be determined accordingly.

d) In the absence of evidence to the contrary, a qualified student residing with a court-appointed guardian who has an established bona fide residence in Montgomery County shall be presumed to be a resident student provided that the guardianship was obtained for reasons concerning the child and not for the primary purpose of attending school or for the convenience of the persons involved.

e) Qualified identified Montgomery County students who are homeless shall be enrolled in accordance with Regulation JEA-RD.

f) A qualified student placed in a group home or foster home in Montgomery County by social service agencies of the State of Maryland, or any other agency specified in Section 4-122 of the Education Article of the *Annotated Code of Maryland* shall be presumed to be a resident student for whom the Montgomery County Public Schools is eligible for reimbursement of actual educational expenses by another Local Educational Agency or the State of Maryland.

g) A qualified student who is a resident of Maryland residing in a valid kinship care arrangement pursuant to Section 4-122 of the Education Article of the *Annotated Code of Maryland* will be presumed to be a resident student for whom the Montgomery County Public Schools is eligible for reimbursement

of actual educational expenses by another local education agency or the State of Maryland.

4. The Residency Compliance Unit will make individual determinations of residency. Individual determinations of residency by the Residency Compliance Unit will be re-evaluated at least annually. The Residency Compliance Unit will make determinations in the following cases:

   a) There is evidence rebutting the presumption of residency or nonresidency set forth in Section 3

   b) When there is a qualified student who is 18 years of age or older and essentially self-supporting or an emancipated minor who may or may not have established a bona fide residence in Montgomery County without regard to the residency of the parents

   c) When there is a qualified student under 18 years of age who is living in Montgomery County with friends or relatives who are not parents or court-appointed guardians

   In addition to individual verification, MCPS reserves the right to initiate specific grade level or schoolwide residency verification activities. The burden of producing evidence establishing bona fide residence is on the student or individual acting on behalf of the student.

5. Admission of Nonresident Students

   a) Regardless of their willingness to pay tuition, nonresident students may be denied admission to the Montgomery County Public Schools.

   b) Except to the extent to which the implementing regulation provides for either a grace period or permits a deposit to be made during the pendancy of an appeal of a determination of nonresidency, before a nonresident student is enrolled in the Montgomery County Public Schools, tuition will be charged and paid unless a waiver is granted as provided below:

      (1) The nonresident student is residing in Montgomery County with a host family for a maximum of one year and has met the criteria established and detailed in MCPS Regulation JEA-RC, *Enrollment and Placement of International and Foreign Students,* including the approval by the supervisor of the International Student Admissions Office

(2) There is a crisis, unusual and extraordinary circumstances fully documented by the parent, guardian, or emancipated student, justifying waiver of tuition

c) Tuition rates will be established annually by the Board of Education upon the recommendation of the superintendent of schools.

d) A non-resident student applicant may request a specific school; however, MCPS reserves the right to determine the school of enrollment.

6. Responsibilities

a) Parents, guardians, or students who have reached the age of majority are responsible for signing an affidavit as to their bona fide residence or nonresidence in Montgomery County as a prerequisite to a student's initial enrollment in the Montgomery County Public Schools. Additionally, there is an acknowledgment that tuition will be paid for any period(s) of nonresidency, even if the period(s) of nonresidency should occur or be identified after the date of initial enrollment.

b) The school principal or designee (or the International Student Admissions Office for noncitizens who have not attended school within the United States at any time during the prior two years) is responsible for making the initial determination of the residency status of students who seek enrollment in a Montgomery County public school and, based on that determination, for taking the appropriate administrative steps specified in MCPS regulations.

c) The Residency Compliance Unit is responsible for determining the residency and tuition status of all students referred to it by the individual schools or the International Student Admission Office.

7. Appeals

Decisions made under this policy and any implementing regulations may be appealed under the provisions of Regulation KLA-RA: *Responding to Citizen Inquiries and Complaints From the Public.* The superintendent or a designee may assign a hearing officer to hear residency and tuition appeal cases on the superintendent's behalf and make recommendations to the superintendent or designee.

D. DESIRED OUTCOME

An effective, efficient, and equitable enrollment process which ensures the right of eligible students to a free public education and minimizes barriers for enrollment.

E. REVIEW AND REPORTING

1. The superintendent will provide a report to the Board of Education at least annually regarding the enrollment of nonresident students and tuition payments.

2. This policy will be reviewed in accordance with the Board of Education Policy BFA, *Policysetting*.

Policy History: Adopted by Resolution No. 366-87, July 14, 1987; amended by Resolution No. 65-92, January 27, 1992; amended by Resolution No. 328-04, June 8, 2004.

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>> Tuition and Fee Schedule for Fall 2008

Printable Version

	COUNTY RESIDENT (CODE 1)						MD STATE RESIDENT (CODE 2)						
CR. HRS.	TUITION	CONS. FEE	FAC. FEE	TECH. FEE	TRANS. FEE	TOTAL	CR. HRS	TUITION	CONS. FEE	FAC. FEE	TECH. FEE	TRANS. FEE	TOTAL
1	99.00	50.00	5.00	5.00	4.00	163.00	1	203.00	50.00	5.00	5.00	4.00	267.00
2	198.00	50.00	10.00	10.00	8.00	276.00	2	406.00	81.20	10.00	10.00	8.00	515.20
3	297.00	59.40	15.00	15.00	12.00	398.40	3	609.00	121.80	15.00	15.00	12.00	772.80
4	396.00	79.20	20.00	20.00	16.00	531.20	4	812.00	162.40	20.00	20.00	16.00	1,030.40
5	495.00	99.00	25.00	25.00	20.00	664.00	5	1,015.00	203.00	25.00	25.00	20.00	1,288.00
6	594.00	118.80	30.00	30.00	24.00	796.80	6	1,218.00	243.60	30.00	30.00	24.00	1,545.60
7	693.00	138.60	35.00	35.00	28.00	929.60	7	1,421.00	284.20	35.00	35.00	28.00	1,803.20
8	792.00	158.40	40.00	40.00	32.00	1,062.40	8	1,624.00	324.80	40.00	40.00	32.00	2,060.80
9	891.00	178.20	45.00	45.00	36.00	1,195.20	9	1,827.00	365.40	45.00	45.00	36.00	2,318.40
10	990.00	198.00	50.00	50.00	40.00	1,328.00	10	2,030.00	406.00	50.00	50.00	40.00	2,576.00
11	1,089.00	217.80	55.00	55.00	44.00	1,460.80	11	2,233.00	446.60	55.00	55.00	44.00	2,833.60
12	1,188.00	237.60	60.00	60.00	48.00	1,593.60	12	2,436.00	487.20	60.00	60.00	48.00	3,091.20
13	1,287.00	257.40	65.00	65.00	52.00	1,726.40	13	2,639.00	527.80	65.00	65.00	52.00	3,348.80
14	1,386.00	277.20	70.00	70.00	56.00	1,859.20	14	2,842.00	568.40	70.00	70.00	56.00	3,606.40
15	1,485.00	297.00	75.00	75.00	60.00	1,992.00	15	3,045.00	609.00	75.00	75.00	60.00	3,864.00
16	1,584.00	316.80	80.00	80.00	64.00	2,124.80	16	3,248.00	649.60	80.00	80.00	64.00	4,121.60
17	1,683.00	336.60	85.00	85.00	68.00	2,257.60	17	3,451.00	690.20	85.00	85.00	68.00	4,379.20
18	1,782.00	356.40	90.00	90.00	72.00	2,390.40	18	3,654.00	730.80	90.00	90.00	72.00	4,636.80
19	1,881.00	376.20	95.00	95.00	76.00	2,523.20	19	3,857.00	771.40	95.00	95.00	76.00	4,894.40
20	1,980.00	396.00	100.00	100.00	80.00	2,656.00	20	4,060.00	812.00	100.00	100.00	80.00	5,152.00

	NON-RESIDENT (CODE 3)					
CR. HRS.	TUITION	CONS. FEE	FAC. FEE	TECH. FEE	TRANS. FEE	TOTAL
1	275.00	55.00	5.00	5.00	4.00	344.00
2	550.00	110.00	10.00	10.00	8.00	688.00
3	825.00	165.00	15.00	15.00	12.00	1,032.00
4	1,100.00	220.00	20.00	20.00	16.00	1,376.00
5	1,375.00	275.00	25.00	25.00	20.00	1,720.00
6	1,650.00	330.00	30.00	30.00	24.00	2,064.00
7	1,925.00	385.00	35.00	35.00	28.00	2,408.00
8	2,200.00	440.00	40.00	40.00	32.00	2,752.00
9	2,475.00	495.00	45.00	45.00	36.00	3,096.00
10	2,750.00	550.00	50.00	50.00	40.00	3,440.00
11	3,025.00	605.00	55.00	55.00	44.00	3,784.00
12	3,300.00	660.00	60.00	60.00	48.00	4,128.00
13	3,575.00	715.00	65.00	65.00	52.00	4,472.00
14	3,850.00	770.00	70.00	70.00	56.00	4,816.00
15	4,125.00	825.00	75.00	75.00	60.00	5,160.00
16	4,400.00	880.00	80.00	80.00	64.00	5,504.00
17	4,675.00	935.00	85.00	85.00	68.00	5,848.00
18	4,950.00	990.00	90.00	90.00	72.00	6,192.00
19	5,225.00	1,045.00	95.00	95.00	76.00	6,536.00
20	5,500.00	1,100.00	100.00	100.00	80.00	6,880.00

CONSOLIDATED FEE (CONS. FEE)
20% of total tuition with a minimum of $50.00 (not to exceed 20% of maximum tuition charge for each resident code). Fee is non-refundable after the first week of classes.

MAJOR FACILITY FEE (FAC. FEE)
This fee is assessed at $5 per credit hour to fund capital facilities. No maximum hours. (Nonrefundable fee)

SPECIAL NOTE
Effective April 17, 1995, by action of the BOT the tuition cap has been eliminated. This schedule shows through 20 hours only in order to provide a guide.

TECHNOLOGY FEE (TECH. FEE)
This fee is assessed to partially offset the costs of technology associated with instructional programs. (Nonrefundable fee)