

# UnitedHealthcare Insurance Company

## UnitedHealthcare Choice Plus

Certificate of Coverage, Riders, Amendments, and Notices

for

CONSUMEROPTIX

**Group Number:** GA0F3551BW **Health Plan:** CW - M6 **Prescription Code:** K35Y  
**Effective Date:** December 1, 2023

Offered and Underwritten by  
UnitedHealthcare Insurance Company

Riders, Amendments, and Notices  
begin immediately following the last page  
of the Certificate of Coverage

# Certificate of Coverage

## UnitedHealthcare Insurance Company

### What Is the Certificate of Coverage?

This *Certificate of Coverage (Certificate)* is part of the Policy that is a legal document between UnitedHealthcare Insurance Company and the Group. The *Certificate* describes Covered Health Care Services, subject to the terms, conditions, exclusions and limitations of the Policy. We issue the Policy based on the Group's *Application* and payment of the required Policy Charges.

In addition to this *Certificate*, the Policy includes:

- The *Schedule of Benefits*.
- The Group's *Application*.
- Riders.
- Amendments.

You can review the Policy at the Group's office during regular business hours.

### Can This Certificate Change?

We may, from time to time, change this *Certificate* by attaching legal documents called Riders and/or Amendments that may change certain provisions of this *Certificate*. When this happens we will send you a new *Certificate*, Rider or Amendment.

### Other Information You Should Have

We have the right to change, interpret, withdraw or add Benefits, or to end the Policy, as permitted by law, without your approval.

On its effective date, this *Certificate* replaces and overrules any *Certificate* that we may have previously issued to you. This *Certificate* will in turn be overruled by any *Certificate* we issue to you in the future.

The Policy will take effect on the date shown in the Policy. Coverage under the Policy starts at 12:01 a.m. and ends at 12:00 midnight in the time zone of the Group's location. The Policy will remain in effect as long as the Policy Charges are paid when they are due, subject to *Section 4: When Coverage Ends*.

We are delivering the Policy in Iowa. The Policy is subject to the laws of the state of Iowa and ERISA, unless the Group is not a private plan sponsor subject to ERISA. To the extent that state law applies, Iowa law governs the Policy.

# Introduction to Your Certificate

This *Certificate* and the other Policy documents describe your Benefits, as well as your rights and responsibilities, under the Policy.

## What Are Defined Terms?

Certain capitalized words have special meanings. We have defined these words in *Section 9: Defined Terms*.

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company. When we use the words "you" and "your," we are referring to people who are Covered Persons, as that term is defined in *Section 9: Defined Terms*.

## How Do You Use This Document?

Read your entire *Certificate* and any attached Riders and/or Amendments. You may not have all of the information you need by reading just one section. Keep your *Certificate* and *Schedule of Benefits* and any attachments in a safe place for your future reference. You can also get this *Certificate* at [www.myuhc.com](http://www.myuhc.com).

Review the Benefit limitations of this *Certificate* by reading the attached *Schedule of Benefits* along with *Section 1: Covered Health Care Services* and *Section 2: Exclusions and Limitations*. Read *Section 8: General Legal Provisions* to understand how this *Certificate* and your Benefits work. Call us if you have questions about the limits of the coverage available to you.

If there is a conflict between this *Certificate* and any summaries provided to you by the Group, this *Certificate* controls.

Please be aware that your Physician is not responsible for knowing or communicating your Benefits.

## How Do You Contact Us?

Call the telephone number listed on your identification (ID) card. Throughout the document you will find statements that encourage you to contact us for more information.

# **Your Responsibilities**

## **Enrollment and Required Contributions**

Benefits are available to you if you are enrolled for coverage under the Policy. Your enrollment options, and the corresponding dates that coverage begins, are listed in *Section 3: When Coverage Begins*. To be enrolled and receive Benefits, both of the following apply:

- Your enrollment must be in accordance with the requirements of the Policy issued to your Group, including the eligibility requirements.
- You must qualify as a Subscriber or a Dependent as those terms are defined in *Section 9: Defined Terms*.

Your Group may require you to make certain payments to them, in order for you to remain enrolled under the Policy. If you have questions about this, contact your Group.

## **Be Aware the Policy Does Not Pay for All Health Care Services**

The Policy does not pay for all health care services. Benefits are limited to Covered Health Care Services. The *Schedule of Benefits* will tell you the portion you must pay for Covered Health Care Services.

## **Decide What Services You Should Receive**

Care decisions are between you and your Physician. We do not make decisions about the kind of care you should or should not receive.

## **Choose Your Physician**

It is your responsibility to select the health care professionals who will deliver your care. We arrange for Physicians and other health care professionals and facilities to participate in a Network. Our credentialing process confirms public information about the professionals' and facilities' licenses and other credentials, but does not assure the quality of their services. These professionals and facilities are independent practitioners and entities that are solely responsible for the care they deliver.

## **Obtain Prior Authorization**

Some Covered Health Care Services require prior authorization. Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. However, if you choose to receive Covered Health Care Services from an out-of-Network provider, you are responsible for obtaining prior authorization before you receive the services. For detailed information on the Covered Health Care Services that require prior authorization, please refer to the *Schedule of Benefits*.

## **Pay Your Share**

You must meet any applicable deductible and pay a Co-payment and/or Co-insurance for most Covered Health Care Services. These payments are due at the time of service or when billed by the Physician, provider or facility. Any applicable deductible, Co-payment and Co-insurance amounts are listed in the *Schedule of Benefits*.

## **Pay the Cost of Excluded Services**

You must pay the cost of all excluded services and items. Review *Section 2: Exclusions and Limitations* to become familiar with the Policy's exclusions.

## **Show Your ID Card**

You should show your ID card every time you request health care services. If you do not show your ID card, the provider may fail to bill the correct entity for the services delivered.

## **File Claims with Complete and Accurate Information**

When you receive Covered Health Care Services from an out-of-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described in *Section 5: How to File a Claim*.

## **Use Your Prior Health Care Coverage**

If you have prior coverage that, as required by state law, extends benefits for a particular condition or a disability, we will not pay Benefits for health care services for that condition or disability until the prior coverage ends. We will pay Benefits as of the day your coverage begins under the Policy for all other Covered Health Care Services that are not related to the condition or disability for which you have other coverage.

# Our Responsibilities

## Determine Benefits

We make administrative decisions regarding whether the Policy will pay for any portion of the cost of a health care service you intend to receive or have received. Our decisions are for payment purposes only. We do not make decisions about the kind of care you should or should not receive. You and your providers must make those treatment decisions.

We have the final authority to do the following:

- Interpret Benefits and the other terms, limitations and exclusions set out in this *Certificate*, the *Schedule of Benefits* and any Riders and/or Amendments.
- Make factual determinations relating to Benefits.

We may assign this authority to other persons or entities that may provide administrative services for the Policy, such as claims processing. The identity of the service providers and the nature of their services may be changed from time to time as we determine. In order to receive Benefits, you must cooperate with those service providers.

## Pay for Our Portion of the Cost of Covered Health Care Services

We pay Benefits for Covered Health Care Services as described in *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*, unless the service is excluded in *Section 2: Exclusions and Limitations*. This means we only pay our portion of the cost of Covered Health Care Services. It also means that not all of the health care services you receive may be paid for (in full or in part) by the Policy.

## Pay Network Providers

It is the responsibility of Network Physicians and facilities to file for payment from us. When you receive Covered Health Care Services from Network providers, you do not have to submit a claim to us.

## Pay for Covered Health Care Services Provided by Out-of-Network Providers

In accordance with any state prompt pay requirements, we pay Benefits after we receive your request for payment that includes all required information. See *Section 5: How to File a Claim*.

## Review and Determine Benefits in Accordance with our Reimbursement Policies

We develop our reimbursement policy guidelines, as we determine, in accordance with one or more of the following methodologies:

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

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), our reimbursement policies are applied to provider billings. We share our reimbursement policies with Physicians and other providers in our Network through our provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. However, out-of-Network providers may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed. You may get copies of our reimbursement policies for yourself or to share with your out-of-Network Physician or provider by contacting us at [www.myuhc.com](http://www.myuhc.com) or the telephone number on your ID card.

We may apply a reimbursement methodology established by *OptumInsight* and/or a third party vendor, which is

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

## **Offer Health Education Services to You**

We may provide you with access to information about additional services that are available to you, such as disease management programs, health education and patient advocacy. It is solely your decision whether to take part in the programs, but we recommend that you discuss them with your Physician.



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# Section 1: Covered Health Care Services

## When Are Benefits Available for Covered Health Care Services?

Benefits are available only when all of the following are true:

- The health care service, including supplies or Pharmaceutical Products, is only a Covered Health Care Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Care Service in *Section 9: Defined Terms*.)
- You receive Covered Health Care Services while the Policy is in effect.
- You receive Covered Health Care Services prior to the date that any of the individual termination conditions listed in *Section 4: When Coverage Ends* occurs.
- The person who receives Covered Health Care Services is a Covered Person and meets all eligibility requirements specified in the Policy.

The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Care Service under the Policy.

This section describes Covered Health Care Services for which Benefits are available. Please refer to the attached *Schedule of Benefits* for details about:

- The amount you must pay for these Covered Health Care Services (including any Annual Deductible, Per Occurrence Deductible, Co-payment and/or Co-insurance).
- Any limit that applies to these Covered Health Care Services (including visit, day and dollar limits on services).
- Any limit that applies to the portion of the Allowed Amount or the Recognized Amount when applicable, you are required to pay in a year (Out-of-Pocket Limit).
- Any responsibility you have for obtaining prior authorization or notifying us.

***Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."***

### 1. Ambulance Services

Emergency ambulance transportation by a licensed ambulance service (either ground or Air Ambulance) to the nearest Hospital where the required Emergency Health Care Services can be performed.

Non-Emergency ambulance transportation by a licensed ambulance service (either ground or Air Ambulance, as we determine appropriate) between facilities only when the transport meets one of the following:

- From an out-of-Network Hospital to the closest Network Hospital when Covered Health Care Services are required.
- To the closest Network Hospital that provides the required Covered Health Care Services that were not available at the original Hospital.
- From a short-term acute care facility to the closest Network long-term acute care facility (LTAC), Network Inpatient Rehabilitation Facility, or other Network sub-acute facility where the required Covered Health Care Services can be delivered.

For the purpose of this Benefit the following terms have the following meanings:

- "Long-term acute care facility (LTAC)" means a facility or Hospital that provides care to people with complex medical needs requiring long-term Hospital stay in an acute or critical setting.

- "Short-term acute care facility" means a facility or Hospital that provides care to people with medical needs requiring short-term Hospital stay in an acute or critical setting such as for recovery following a surgery, care following sudden Sickness, Injury, or flare-up of a chronic Sickness.
- "Sub-acute facility" means a facility that provides intermediate care on short-term or long-term basis.

## 2. Cellular and Gene Therapy

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

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

## 3. Clinical Trials

Routine patient care costs incurred while taking part in a qualifying clinical trial for the treatment of:

- Cancer or other life-threatening disease or condition. For purposes of this Benefit, a life-threatening disease or condition is one which is likely to cause death unless the course of the disease or condition is interrupted.
- Cardiovascular disease (cardiac/stroke) which is not life threatening, when we determine the clinical trial meets the qualifying clinical trial criteria stated below.
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, when we determine the clinical trial meets the qualifying clinical trial criteria stated below.
- Other diseases or disorders which are not life threatening, when we determine the clinical trial meets the qualifying clinical trial criteria stated below.

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

Benefits are available only when you are clinically eligible, as determined by the researcher, to take part in the qualifying clinical trial.

Routine patient care costs for qualifying clinical trials include:

- Covered Health Care Services for which Benefits are typically provided absent a clinical trial.
- Covered Health Care Services required solely for the following:
  - The provision of the Experimental or Investigational Service(s) or item.
  - The clinically appropriate monitoring of the effects of the service or item, or
  - The prevention of complications.
- Covered Health Care Services needed for reasonable and necessary care arising from the receipt of an Experimental or Investigational Service(s) or item.
- Covered Health Care Services for routine patient care include costs related to the care method that is under evaluation in a clinical trial.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service(s) or item. The only exceptions to this are:
  - Certain *Category B* devices.
  - Certain promising interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with our medical and drug policies.
- Items and services provided solely to meet data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that clearly does not meet widely accepted and established standards of care for a particular diagnosis.
- Items and services provided by the research sponsors free of charge for any person taking part in the trial.

With respect to cancer or other life-threatening diseases or conditions, a qualifying clinical trial is a Phase I, Phase

II, Phase III, or Phase IV clinical trial. It takes place in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition. It meets any of the following criteria in the bulleted list below.

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

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - *National Institutes of Health (NIH)*. (Includes *National Cancer Institute (NCI)*.)
  - *Centers for Disease Control and Prevention (CDC)*.
  - *Agency for Healthcare Research and Quality (AHRQ)*.
  - *Centers for Medicare and Medicaid Services (CMS)*.
  - A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA)*.
  - A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.
  - The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* if the study or investigation has been reviewed and approved through a system of peer review. The peer review system is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
    - ◆ Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*.
    - ◆ Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation takes place under an investigational new drug application reviewed by the *U.S. Food and Drug Administration*.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- The clinical trial must have a written protocol that describes a scientifically sound study. It must have been approved by all relevant institutional review boards (*IRBs*) before you are enrolled in the trial. We may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Care Service and is not otherwise excluded under the Policy.

#### **4. Congenital Heart Disease (CHD) Surgeries**

CHD surgeries which are ordered by a Physician. CHD surgical procedures include surgeries to treat conditions such as:

- Coarctation of the aorta.
- Aortic stenosis.
- Tetralogy of Fallot.
- Transposition of the great vessels.
- Hypoplastic left or right heart syndrome.

Benefits include the facility charge and the charge for supplies and equipment. Benefits for Physician services are described under *Physician Fees for Surgical and Medical Services*.

Surgery may be performed as open or closed surgical procedures or may be performed through interventional cardiac catheterization.

You can call us at the telephone number on your ID card for information about our specific guidelines regarding

Benefits for *CHD* services.

## 5. Dental Services - Accident Only

Dental services when all of the following are true:

- Treatment is needed because of accidental damage.
- You receive dental services from a Doctor of Dental Surgery or Doctor of Medical Dentistry.
- The dental damage is severe enough that first contact with a Physician or dentist happened within 72 hours of the accident. (You may request this time period be longer if you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

Please note that dental damage that happens as a result of normal activities of daily living or extraordinary use of the teeth is not considered an accidental Injury. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

Dental services to repair damage caused by accidental Injury must follow these time-frames:

- Treatment is started within three months of the accident, or if not a Covered Person at the time of the accident, within the first three months of coverage under the Policy, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care).
- Treatment must be completed within 12 months of the accident, or if not a Covered Person at the time of the accident, within the first 12 months of coverage under the Policy.

Benefits for treatment of accidental Injury are limited to the following:

- Emergency exam.
- Diagnostic X-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.
- Prefabricated post and core.
- Simple minimal restorative procedures (fillings).
- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to Injury with implant, dentures or bridges.

## 6. Diabetes Services

### Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Services must be ordered by a Physician and provided by appropriately licensed or registered health care professionals.

Benefits also include medical eye exams (dilated retinal exams) and preventive foot care for diabetes.

### Diabetic Self-Management Items

Insulin pumps and supplies and continuous glucose monitors for the management and treatment of diabetes, based upon your medical needs. An insulin pump is subject to all the conditions of coverage stated under *Durable Medical Equipment (DME)*, *Orthotics and Supplies*. Benefits for blood glucose meters including continuous glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described under *Section 10: Outpatient Prescription Drug Products*.

Benefits for diabetes self-management training and education will be provided under both of the following conditions:

- The Physician managing your diabetes condition certifies that the services are needed under a comprehensive plan of care related to your diabetic condition to ensure therapy compliance or to provide you with the necessary skills and knowledge to participate in the management of your own condition.

- The program itself is certified by the *Iowa Department of Public Health*.

## 7. Durable Medical Equipment (DME), Orthotics and Supplies

Benefits are provided for DME and certain orthotics and supplies. If more than one item can meet your functional needs, Benefits are available only for the item that meets the minimum specifications for your needs. If you purchase an item that exceeds these minimum specifications, we will pay only the amount that we would have paid for the item that meets the minimum specifications, and you will be responsible for paying any difference in cost.

### *DME and Supplies*

Examples of DME and supplies include:

- Equipment to help mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Negative pressure wound therapy pumps (wound vacuums).
- Mechanical equipment needed for the treatment of long term or sudden respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related needed supplies as described under *Diabetes Services*.
- External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this *Certificate*.

Benefits include lymphedema stockings for the arm as required by the *Women's Health and Cancer Rights Act of 1998*.

Benefits also include dedicated speech generating devices and tracheo-esophageal voice devices required for treatment of severe speech impairment or lack of speech directly due to Sickness or Injury. Benefits for the purchase of these devices are available only after completing a required three-month rental period. Benefits are limited as stated in the *Schedule of Benefits*.

### *Orthotics*

Orthotic braces, including needed changes to shoes to fit braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are a Covered Health Care Service.

We will decide if the equipment should be purchased or rented.

Benefits are available for repairs and replacement, except as described in *Section 2: Exclusions and Limitations*, under *Medical Supplies and Equipment*.

These Benefits apply to external DME. Unless otherwise excluded, items that are fully implanted into the body are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Service categories in this *Certificate*.

## 8. Emergency Health Care Services - Outpatient

Services that are required to stabilize or begin treatment in an Emergency. Emergency Health Care Services must be received on an outpatient basis at a Hospital or Alternate Facility.

Benefits include the facility charge, supplies and all professional services required to stabilize your condition and/or begin treatment. This includes placement in an observation bed to monitor your condition (rather than being admitted to a Hospital for an Inpatient Stay).

## 9. Enteral Nutrition

Benefits are provided for enteral formulas and low protein modified food products, administered either orally or by tube feeding as the primary source of nutrition, for certain conditions which require specialized nutrients or formulas. Examples of conditions include:

- Metabolic diseases such as phenylketonuria (PKU) and maple syrup urine disease.
- Severe food allergies.
- Impaired absorption of nutrients caused by disorders affecting the gastrointestinal tract.

Benefits for prescription or over-the-counter formula and products are available when a Physician issues a prescription or written order stating the formula or product is Medically Necessary for the therapeutic treatment of a condition requiring specialized nutrients and specifying the quantity and the duration of the prescription or order. The formula or product must be administered under the direction of a Physician or registered dietitian.

For the purpose of this Benefit, "enteral formulas" include:

- Amino acid-based elemental formulas.
- Extensively hydrolyzed protein formulas.
- Modified nutrient content formulas.

For the purpose of this Benefit, "severe food allergies" mean allergies which if left untreated will result in:

- Malnourishment;
- Chronic physical disability;
- Intellectual disability; or
- Loss of life.

## 10. Fertility Preservation for Iatrogenic Infertility

Benefits are available for fertility preservation for medical reasons that cause irreversible infertility such as chemotherapy, radiation treatment, and bilateral oophorectomy due to cancer. Services include the following procedures, when provided by or under the care or supervision of a Physician:

- Collection of sperm.
- Cryo-preservation of sperm.
- Ovarian stimulation, retrieval of eggs and fertilization.
- Oocyte cryo-preservation.
- Embryo cryo-preservation.

Benefits for medications related to the treatment of fertility preservation are provided as described under Section 10: *Outpatient Prescription Drug Products* or under *Pharmaceutical Products - Outpatient* in this section.

Benefits are not available for embryo transfer.

Benefits are not available for long-term storage costs (greater than one year).

## 11. Gender Dysphoria

Benefits for the treatment of gender dysphoria provided by or under the direction of a Physician.

For the purpose of this Benefit, "gender dysphoria" is a disorder characterized by the specific diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

## 12. Habilitative Services

For purposes of this Benefit, "habilitative services" means Skilled Care services that are part of a prescribed treatment plan or maintenance program to help a person with a disabling condition to keep, learn or improve skills and functioning for daily living. We will decide if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition are not considered habilitative services.

Habilitative services are limited to:

- Physical therapy.
- Occupational therapy.
- Manipulative Treatment.
- Speech therapy.
- Post-cochlear implant aural therapy.
- Cognitive therapy.

Benefits are provided for habilitative services for both inpatient services and outpatient therapy when you have a disabling condition when both of the following conditions are met:

- Treatment is administered by any of the following:
  - Licensed speech-language pathologist.
  - Licensed audiologist.
  - Licensed occupational therapist.
  - Licensed physical therapist.
  - Physician.
- Treatment must be proven and not Experimental or Investigational.

The following are not habilitative services:

- Custodial Care.
- Respite care.
- Day care.
- Therapeutic recreation.
- Vocational training.
- Residential Treatment.
- A service that does not help you meet functional goals in a treatment plan within a prescribed time frame.
- Services solely educational in nature.
- Educational services otherwise paid under state or federal law.

We may require the following be provided:

- Treatment plan.
- Medical records.
- Clinical notes.
- Other necessary data to allow us to prove that medical treatment is needed.

When the treating provider expects that continued treatment is or will be required to allow you to achieve progress that is capable of being demonstrated, we may request a treatment plan that includes:

- Diagnosis.
- Proposed treatment by type, frequency, and expected duration of treatment.
- Expected treatment goals.
- Frequency of treatment plan updates.

Habilitative services provided in your home by a Home Health Agency are provided as described under *Home Health Care*. Habilitative services provided in your home other than by a Home Health Agency are provided as described under this section.

Benefits for DME and prosthetic devices, when used as a part of habilitative services, are described under *Durable Medical Equipment (DME), Orthotics and Supplies and Prosthetic Devices*.



### **13. Hearing Aids**

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

Benefits are available for a hearing aid that is purchased due to a written recommendation by a Physician. Benefits are provided for the hearing aid and associated fitting charges and testing.

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

Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Services categories in this *Certificate*. They are only available if you have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals prevent the use of a wearable hearing aid.
- Hearing loss severe enough that it would not be remedied by a wearable hearing aid.

### **14. Home Health Care**

Services received from a Home Health Agency that are all of the following:

- Ordered by a Physician.
- Provided in your home by a registered nurse, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.
- Provided on a part-time, Intermittent Care schedule.
- Provided when Skilled Care is required.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management.

#### **Private Duty Nursing**

Benefits for Private Duty Nursing services provided in the home when provided through a Home Health Agency and authorized in advance by us. Your Physician must certify to us that Private Duty Nursing services are Medically Necessary for your condition and not merely custodial in nature. Private Duty Nursing services may be provided if they are determined by us to be more cost effective than can be provided in a facility setting.

### **15. Hospice Care**

Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. It includes the following:

- Physical, psychological, social, spiritual and respite care for the terminally ill person.
- Short-term grief counseling for immediate family members while you are receiving hospice care.

Benefits are available when you receive hospice care from a licensed hospice agency.

You can call us at the telephone number on your ID card for information about our guidelines for hospice care.

### **16. Hospital - Inpatient Stay**

Services and supplies provided during an Inpatient Stay in a Hospital.

Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).

- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

## **17. Lab, X-Ray and Diagnostic - Outpatient**

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office include:

- Lab and radiology/X-ray.
- Mammography.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)
- Genetic Testing ordered by a Physician which results in available medical treatment options following Genetic Counseling.
- Presumptive Drug Tests and Definitive Drug Tests.

Benefits include screening mammography. Benefits for screening mammography include:

- One baseline mammogram for women 35 to 39 years of age.
- A mammogram for women 40 to 49 years of age every two years or more frequently based on a Physician's recommendation.
- A mammogram every year for women 50 years of age or older.

Mammography screenings that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force are described under *Preventive Care Services*.

Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services*.

CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Major Diagnostic and Imaging - Outpatient*.

## **18. Major Diagnostic and Imaging - Outpatient**

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

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

## **19. Mental Health Care and Substance-Related and Addictive Disorders Services**

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

- A licensed master social worker (so licensed by the board of social work) providing services under the supervision of an independent social worker (so licensed by the board of social work).
- A licensed mental health counselor or a licensed marital and family therapist who holds a temporary license to practice mental health counseling or marital and family therapy and who provides services under the supervision of a qualified supervisor as determined by the board of behavioral science by rule.
- A provisionally licensed psychologist practicing under the supervision of a supervisor who meets the qualifications determined by the board of psychology by rule.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

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

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Crisis intervention.
- Mental Health Care Services for Autism Spectrum Disorder (including Intensive Behavioral Therapies such as *Applied Behavior Analysis (ABA)*) that are the following:
  - Focused on the treatment of core deficits of Autism Spectrum Disorder.
  - Provided by a *Board Certified Behavior Analyst (BCBA)* or other qualified provider under the appropriate supervision.
  - Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.

This section describes only the behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Care Service for which Benefits are available under the applicable medical Covered Health Care Services categories in this *Certificate*.

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

We encourage you to contact the Mental Health/Substance-Related and Addictive Disorders Designee for assistance in locating a provider and coordination of care.

Benefits under this section include Biologically Based Mental Illness as required by Iowa insurance law. Benefits for the treatment of Biologically Based Mental Illness do not include marital, family, educational, developmental or training services; care that is substantially custodial in nature; services and supplies that are not medically necessary or clinically appropriate; or experimental treatment.

## **20. Obesity - Weight Loss Surgery**

Surgical treatment of obesity when provided by or under the direction of a Physician when you have a body mass index (BMI) greater than 40.

Surgical treatment of obesity when provided by or under the direction of a Physician when either of the following criteria is met:

- You have a body mass index (BMI) of greater than 40.
- You have a body mass index (BMI) of greater than 35 with complicating coexisting medical conditions or diseases (such as sleep apnea or diabetes) directly related to, or made worse by, obesity.

## **21. Ostomy Supplies**

Benefits for ostomy supplies are limited to the following:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.

- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

## **22. Pharmaceutical Products - Outpatient**

Pharmaceutical Products for Covered Health Care Services administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in your home.

Benefits are provided for Pharmaceutical Products which, due to their traits (as determined by us), are administered or directly supervised by a qualified provider or licensed/certified health professional. Depending on where the Pharmaceutical Product is administered, Benefits will be provided for administration of the Pharmaceutical Product under the corresponding Benefit category in this *Certificate*. Benefits for medication normally available by a prescription or order or refill are provided as described under *Section 10: Outpatient Prescription Drug Products*

If you require certain Pharmaceutical Products, including Specialty Pharmaceutical Products, we may direct you to a Designated Dispensing Entity. Such Designated Dispensing Entities may include an outpatient pharmacy, specialty pharmacy, Home Health Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

If you/your provider are directed to a Designated Dispensing Entity and you/your provider choose not to get your Pharmaceutical Product from a Designated Dispensing Entity, Network Benefits are not available for that Pharmaceutical Product.

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you must use a different Pharmaceutical Product and/or prescription drug product first. You may find out whether a particular Pharmaceutical Product is subject to step therapy requirements by contacting us at [www.myuhc.com](http://www.myuhc.com) or the telephone number on your ID card.

We may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs by contacting us at [www.myuhc.com](http://www.myuhc.com) or the telephone number on your ID card.

## **23. Physician Fees for Surgical and Medical Services**

Physician fees for surgical procedures and other medical services received on an outpatient or inpatient basis in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls.

## **24. Physician's Office Services - Sickness and Injury**

Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided regardless of whether the Physician's office is freestanding, located in a clinic or located in a Hospital.

Covered Health Care Services include medical education services that are provided in a Physician's office by appropriately licensed or registered health care professionals when both of the following are true:

- Education is required for a disease in which patient self-management is a part of treatment.
- There is a lack of knowledge regarding the disease which requires the help of a trained health professional.

Covered Health Care Services include Genetic Counseling.

Benefits include allergy injections.

Covered Health Care Services for preventive care provided in a Physician's office are described under *Preventive Care Services*.

Benefits for CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Major Diagnostic and Imaging - Outpatient*.

When a test is performed or a sample is drawn in the Physician's office, Benefits for the analysis or testing of a

lab, radiology/X-ray or other diagnostic service, whether performed in or out of the Physician's office, are described under *Lab, X-ray and Diagnostic - Outpatient*.

## 25. Pregnancy - Maternity Services

Benefits for Pregnancy include all maternity-related medical services for prenatal care, postnatal care, delivery and any related complications.

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

We will pay Benefits for an Inpatient Stay of at least:

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

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.

In the event of a discharge from the Hospital prior to the minimum stay required, a post-discharge follow-up visit will be provided to the mother and newborn child by providers competent in postpartum care and newborn assessment.

## 26. Preimplantation Genetic Testing (PGT) and Related Services

Preimplantation Genetic Testing (PGT) performed to identify and to prevent genetic medical conditions from being passed onto offspring. To be eligible for Benefits the following must be met:

- PGT must be ordered by a Physician after Genetic Counseling.
- The genetic medical condition, if passed onto offspring, would result in significant health problems or severe disability and be caused by a single gene (detectable by PGT-M) or structural changes of a parents' chromosome (detectable by PGT-SR).
- Benefits are limited to PGT for the specific genetic disorder and the following related services when provided by or under the supervision of a Physician:
  - Ovulation induction (or controlled ovarian stimulation).
  - Egg retrieval, fertilization and embryo culture.
  - Embryo biopsy.
  - Embryo transfer.
  - Cryo-preservation and short-term embryo storage (less than one year).

Benefits are not available for long-term storage costs (greater than one year).

## 27. Preventive Care Services

Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*. Benefits for mammography screenings that do not have in effect a rating of "A" or "B" are described under *Lab, X-Ray and Diagnostic - Outpatient*.
- Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.

- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

Benefits defined under the *Health Resources and Services Administration (HRSA)* requirement include one breast pump per Pregnancy in conjunction with childbirth. Breast pumps must be ordered by or provided by a Physician. You can find more information on how to access Benefits for breast pumps by contacting us at [www.myuhc.com](http://www.myuhc.com) or the telephone number on your ID card.

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

- Which pump is the most cost effective.
- Whether the pump should be purchased or rented (and the duration of any rental).
- Timing of purchase or rental.

## 28. Prosthetic Devices

External prosthetic devices that replace a limb or a body part, limited to:

- Artificial arms, legs, feet and hands.
- Artificial face, eyes, ears and nose.
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras. Benefits for lymphedema stockings for the arm are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies*.

Benefits are provided only for external prosthetic devices and do not include any device that is fully implanted into the body. Internal prosthetics are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Service categories in this *Certificate*.

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

The prosthetic device must be ordered or provided by, or under the direction of a Physician.

Benefits are available for repairs and replacement, except as described in *Section 2: Exclusions and Limitations*, under *Devices, Appliances and Prosthetics*.

## 29. Reconstructive Procedures

Reconstructive procedures when the primary purpose of the procedure is either of the following:

- Treatment of a medical condition.
- Improvement or restoration of physiologic function.

Reconstructive procedures include surgery or other procedures which are related to an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that you may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Care Service. You can call us at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

### **30. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment**

Short-term outpatient rehabilitation services limited to:

- Physical therapy.
- Occupational therapy.
- Manipulative Treatment.
- Speech therapy.
- Pulmonary rehabilitation therapy.
- Cardiac rehabilitation therapy.
- Post-cochlear implant aural therapy.
- Cognitive rehabilitation therapy.

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Rehabilitative services provided in your home by a Home Health Agency are provided as described under *Home Health Care*. Rehabilitative services provided in your home other than by a Home Health Agency are provided as described under this section.

Benefits can be denied or shortened when either of the following applies:

- You are not progressing in goal-directed rehabilitation services.
- Rehabilitation goals have previously been met.

Benefits are not available for maintenance/preventive treatment.

For outpatient rehabilitative services for speech therapy we will pay Benefits for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, or Congenital Anomaly. We will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or stroke.

### **31. Scopic Procedures - Outpatient Diagnostic and Therapeutic**

Diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

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

- Colonoscopy.
- Sigmoidoscopy.
- Diagnostic endoscopy.

Please note that Benefits do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for all other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Benefits that apply to certain preventive screenings are described under *Preventive Care Services*.

### **32. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services**

Services and supplies provided during an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).

- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Please note that Benefits are available only if both of the following are true:

- If the first confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a cost effective option to an Inpatient Stay in a Hospital.
- You will receive Skilled Care services that are not primarily Custodial Care.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management.

Benefits can be denied or shortened when either of the following applies:

- You are not progressing in goal-directed rehabilitation services.
- Discharge rehabilitation goals have previously been met.

We will also provide coverage for the cost of skilled nursing care in a Hospital if the level of care needed by the Covered Person has been reclassified from acute care to skilled nursing care and no designated skilled nursing care beds or swing beds are available in the Hospital or in another Hospital or health care facility within a thirty-mile radius of the Hospital. This coverage will be provided at the skilled nursing care rate.

### **33. Surgery - Outpatient**

Surgery and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits include certain scopic procedures. Examples of surgical scopic procedures include:

- Arthroscopy.
- Laparoscopy.
- Bronchoscopy.
- Hysteroscopy.

Examples of surgical procedures performed in a Physician's office are mole removal, ear wax removal, and cast application.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

### **34. Temporomandibular Joint (TMJ) Services**

Services for the evaluation and treatment of TMJ and associated muscles.

Diagnosis: Examination, radiographs and applicable imaging studies and consultation.

Non-surgical treatment including:

- Clinical exams.
- Oral appliances (orthotic splints).
- Arthrocentesis.
- Trigger-point injections.

Benefits are provided for surgical treatment if the following criteria are met:

- There is radiographic evidence of joint abnormality.
- Non-surgical treatment has not resolved the symptoms.
- Pain or dysfunction is moderate or severe.

Benefits for surgical services include:

- Arthrocentesis.



- Arthroscopy.
- Arthroplasty.
- Arthrotomy.
- Open or closed reduction of dislocations.

Benefits for surgical services also include FDA-approved TMJ prosthetic replacements when all other treatment has failed.

### **35. Therapeutic Treatments - Outpatient**

Therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including:

- Dialysis (both hemodialysis and peritoneal dialysis).
- Intravenous chemotherapy or other intravenous infusion therapy.
- Radiation oncology.

Covered Health Care Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered health care professionals when both of the following are true:

- Education is required for a disease in which patient self-management is a part of treatment.
- There is a lack of knowledge regarding the disease which requires the help of a trained health professional.

Benefits include:

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

### **36. Transplantation Services**

Organ and tissue transplants, including CAR-T cell therapy for malignancies, when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Care Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include:

- Bone marrow, including CAR-T cell therapy for malignancies.
- Heart.
- Heart/lung.
- Lung.
- Kidney.
- Kidney/pancreas.
- Liver.
- Liver/small intestine.
- Pancreas.
- Small intestine.
- Cornea.

Donor costs related to transplantation are Covered Health Care Services and are payable through the organ recipient's coverage under the Policy, limited to donor:

- Identification.
- Evaluation.
- Organ removal.
- Direct follow-up care.

You can call us at the telephone number on your ID card for information about our specific guidelines regarding Benefits for transplant services.

### **37. Urgent Care Center Services**

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

### **38. Urinary Catheters**

Benefits for external indwelling and intermittent urinary catheters for incontinence or retention.

Benefits include related urologic supplies for indwelling catheters limited to:

- Urinary drainage bag and insertion tray (kit).
- Anchoring device.
- Irrigation tubing set.

### **39. Virtual Care Services**

Virtual care for Covered Health Care Services that includes the diagnosis and treatment of less serious medical conditions. Virtual care provides communication of medical information in real-time between the patient and a distant Physician or health specialist, outside of a medical facility (for example, from home or from work).

Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting us at [www.myuhc.com](http://www.myuhc.com) or the telephone number on your ID card.

Benefits are available for urgent, on-demand health care delivered through live audio with video conferencing or audio only technology for treatment of acute but non-emergency medical needs.

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

Benefits do not include email or fax, or for services that occur within medical facilities (CMS defined originating facilities).

### **40. Wigs**

Benefits are available for the first wig following cancer treatment, not to exceed one per calendar year. Benefits under this section do not include wigs regardless of the reason for hair loss except as described above.

## **Additional Benefits Required By Iowa Law**

### **41. Dental Anesthesia and Hospital Charges**

General anesthesia and Hospital or ambulatory surgical center charges for dental care services provided to any of the following:

- A covered Dependent child under the age of fourteen, when the treating Physician and a licensed dentist determine that treatment in a Hospital or ambulatory surgical center is necessary due to a dental condition or developmental disability for which patient management in the dental office has proven to be ineffective.
- Any Covered Person who has been determined by the treating Physician or a licensed dentist to have one or more medical conditions that would create significant or undue medical risk, in the course of any necessary dental treatment or surgery, if not rendered in a Hospital or surgical center.

## **42. Telehealth Services**

Benefits include Telehealth Services provided by health care professionals. Health care services are available on the same basis as similar services provided through in-person consultation.

For the purpose of this Benefit, "Telehealth" means the delivery of health care services through the use of real time interactive audio and video, or other real-time interactive electronic media, regardless of where the health care professional and the Covered Person are each located.

Telehealth does not include the delivery of health care services delivered solely through an audio-only telephone, electronic mail message, or facsimile transmission.

## Section 2: Exclusions and Limitations

### How Do We Use Headings in this Section?

To help you find exclusions, we use headings (for example *A. Alternative Treatments* below). The headings group services, treatments, items, or supplies that fall into a similar category. Exclusions appear under the headings. A heading does not create, define, change, limit or expand an exclusion. All exclusions in this section apply to you.

### We Do Not Pay Benefits for Exclusions

We will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Care Services, except as may be specifically provided for in *Section 1: Covered Health Care Services* or through a Rider to the Policy.

### Where Are Benefit Limitations Shown?

When Benefits are limited within any of the Covered Health Care Service categories described in *Section 1: Covered Health Care Services*, those limits are stated in the corresponding Covered Health Care Service category in the *Schedule of Benefits*. Limits may also apply to some Covered Health Care Services that fall under more than one Covered Health Care Service category. When this occurs, those limits are also stated in the *Schedule of Benefits* table. Please review all limits carefully, as we will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

***Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."***

#### A. Alternative Treatments

1. Acupressure and acupuncture.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.
6. Wilderness, adventure, camping, outdoor, or similar programs.
7. Art therapy, music therapy, dance therapy, animal-assisted therapy, and other forms of alternative treatment as defined by the *National Center for Complementary and Integrative Health (NCCIH)* of the *National Institutes of Health*. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in *Section 1: Covered Health Care Services*.

#### B. Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all related expenses, including hospitalizations and anesthesia).

This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* or general anesthesia and Hospital or ambulatory surgical center charges connected with dental services for which Benefits are provided under *Dental Anesthesia and Hospital Charges* in *Section 1: Covered Health Care Services*.

This exclusion does not apply to dental care (oral exam, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Policy, limited to:

- Transplant preparation.
- Prior to the initiation of immunosuppressive drugs.
- The direct treatment of acute traumatic Injury, cancer or cleft palate.
- Cleft palate surgery, including orthodontic services required for surgical management.

Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of tooth decay or cavities resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded.

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

- Removal, restoration and replacement of teeth.
- Medical or surgical treatments of dental conditions.
- Services to improve dental clinical outcomes.

This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement or the *Health Resources and Services Administration (HRSA)* requirement. This exclusion also does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Care Services*.

3. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Care Services*.
4. Dental braces (orthodontics).
5. Treatment of congenitally missing, malpositioned or supernumerary teeth, even if part of a Congenital Anomaly.

## **C. Devices, Appliances and Prosthetics**

1. Devices used as safety items or to help performance in sports-related activities.
2. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces. This exclusion does not apply to cranial molding helmets and cranial banding that meet clinical criteria. This exclusion does not apply to braces for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services*.
3. The following items are excluded, even if prescribed by a Physician:
  - Blood pressure cuff/monitor.
  - Enuresis alarm.
  - Non-wearable external defibrillator.
  - Trusses.
  - Ultrasonic nebulizers.
4. Devices and computers to help in communication and speech except for dedicated speech generating devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services*.
5. Oral appliances for snoring.
6. Repair or replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

7. Diagnostic or monitoring equipment purchased for home use, unless otherwise described as a Covered Health Care Service.
8. Powered and non-powered exoskeleton devices.

## **D. Drugs**

1. Prescription drug products for outpatient use that are filled by a prescription order or refill.
2. Self-administered or self-infused medications. This exclusion does not apply to medications which, due to their traits (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to certain hemophilia treatment centers that are contracted with a specific hemophilia treatment center fee schedule that allows medications used to treat bleeding disorders to be dispensed directly to Covered Persons for self-administration.
3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and used while in the Physician's office.
4. Over-the-counter drugs and treatments.
5. Growth hormone therapy.
6. Certain New Pharmaceutical Products and/or new dosage forms until the date as determined by us or our designee, but no later than December 31st of the following calendar year.

This exclusion does not apply if you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment). If you have a life-threatening Sickness or condition, under such circumstances, Benefits may be available for the New Pharmaceutical Product to the extent provided in *Section 1: Covered Health Care Services*.

7. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.
8. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.
9. A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year.
10. Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year.
11. Certain Pharmaceutical Products that have not been prescribed by a Specialist.
12. Compounded drugs that contain certain bulk chemicals. Compounded drugs that are available as a similar commercially available Pharmaceutical Product.

## **E. Experimental or Investigational or Unproven Services**

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Care Services*.

## **F. Foot Care**

### **1. Routine foot care. Examples include:**

- Cutting or removal of corns and calluses.
- Nail trimming, nail cutting, or nail debridement.
- Hygienic and preventive maintenance foot care including cleaning and soaking the feet and applying skin creams in order to maintain skin tone.

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

2. Treatment of flat feet.
3. Treatment of subluxation of the foot.
4. Shoes.
5. Shoe orthotics.
6. Shoe inserts.
7. Arch supports.

## **G. Gender Dysphoria**

### **1. Cosmetic Procedures, including the following:**

- Abdominoplasty.
- Blepharoplasty.
- Breast enlargement, including augmentation mammoplasty and breast implants.
- Body contouring, such as lipoplasty.
- Brow lift.
- Calf implants.
- Cheek, chin, and nose implants.
- Injection of fillers or neurotoxins.
- Face lift, forehead lift, or neck tightening.
- Facial bone remodeling for facial feminizations.
- Hair removal, except as part of a genital reconstruction procedure by a Physician for the treatment of gender dysphoria.
- Hair transplantation.
- Lip augmentation.
- Lip reduction.
- Liposuction.

- Mastopexy.
- Pectoral implants for chest masculinization.
- Rhinoplasty.
- Skin resurfacing.
- Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's apple).
- Voice modification surgery.
- Voice lessons and voice therapy.

## H. Medical Supplies and Equipment

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:

- Compression stockings.
- Ace bandages.
- Gauze and dressings.

This exclusion does not apply to:

- Disposable supplies necessary for the effective use of DME or prosthetic devices for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies and Prosthetic Devices* in *Section 1: Covered Health Care Services*. This exception does not apply to supplies for the administration of medical food products.
  - Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Care Services*. Please note that Benefits for diabetic medications and supplies are available under *Section 10: Outpatient Prescription Drug Products* and not this medical plan.
  - Ostomy supplies for which Benefits are provided as described under *Ostomy Supplies* in *Section 1: Covered Health Care Services*.
  - Urinary catheters and related urologic supplies for which Benefits are provided as described under *Urinary Catheters* in *Section 1: Covered Health Care Services*.
2. Tubings and masks except when used with DME as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services*.
3. Prescribed or non-prescribed publicly available devices, software applications and/or monitors that can be used for non-medical purposes.
4. Repair or replacement of DME or orthotics due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

## I. Mental Health Care and Substance-Related and Addictive Disorders

In addition to all other exclusions listed in this *Section 2: Exclusions and Limitations*, the exclusions listed directly below apply to services described under *Mental Health Care and Substance-Related and Addictive Disorders Services* in *Section 1: Covered Health Care Services*.

1. Services performed in connection with conditions not classified in the current edition of the *International Classification of Diseases* section on *Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Outside of an assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
3. Outside of an assessment, services as treatments for the primary diagnoses of learning disabilities, gambling disorder, and paraphilic disorders.



4. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.
5. Tuition or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act*.
6. Outside of an assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
7. Transitional Living services.
8. Non-Medical 24-Hour Withdrawal Management.
9. High intensity residential care, including *American Society of Addiction Medicine (ASAM) Criteria*, for Covered Persons with substance-related and addictive disorders who are unable to participate in their care due to significant cognitive impairment.

## **J. Nutrition**

1. Individual and group nutritional counseling, including non-specific disease nutritional education such as general good eating habits, calorie control or dietary preferences. This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement. This exclusion also does not apply to medical or behavioral/mental health related nutritional education services that are provided as part of treatment for a disease by appropriately licensed or registered health care professionals when both of the following are true:
  - Nutritional education is required for a disease in which patient self-management is a part of treatment.
  - There is a lack of knowledge regarding the disease which requires the help of a trained health professional.
2. Food of any kind, infant formula, standard milk-based formula, and donor breast milk. This exclusion does not apply to enteral formula and other modified food products for which Benefits are provided as described under *Enteral Nutrition* in *Section 1: Covered Health Care Services*.
3. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements and electrolytes.

## **K. Personal Care, Comfort or Convenience**

1. Television.
2. Telephone.
3. Beauty/barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
  - Air conditioners, air purifiers and filters and dehumidifiers.
  - Batteries and battery chargers.
  - Breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the *Health Resources and Services Administration (HRSA)* requirement.
  - Car seats.
  - Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners.
  - Exercise equipment.
  - Home modifications such as elevators, handrails and ramps.
  - Hot and cold compresses.

- Hot tubs.
- Humidifiers.
- Jacuzzis.
- Mattresses.
- Medical alert systems.
- Motorized beds.
- Music devices.
- Personal computers.
- Pillows.
- Power-operated vehicles.
- Radios.
- Saunas.
- Stair lifts and stair glides.
- Strollers.
- Safety equipment.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

## **L. Physical Appearance**

1. Cosmetic Procedures. See the definition in *Section 9: Defined Terms*. Examples include:
  - Pharmacological regimens, nutritional procedures or treatments.
  - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
  - Skin abrasion procedures performed as a treatment for acne.
  - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. This exclusion does not apply to liposuction for which Benefits are provided as described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.
  - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
  - Treatment for spider veins.
  - Sclerotherapy treatment of veins.
  - Hair removal or replacement by any means, except for hair removal as part of genital reconstruction prescribed by a Physician for the treatment of gender dysphoria.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the first breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.
3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, or flexibility.
5. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.

6. Wigs regardless of the reason for the hair loss, except as described under *Section 1: Covered Health Care Services*.

## **M. Procedures and Treatments**

1. Removal of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).
3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
4. Rehabilitation services and Manipulative Treatment to improve general physical conditions that are provided to reduce potential risk factors, where improvement is not expected, including routine, long-term or maintenance/preventive treatment.
5. Rehabilitation services for speech therapy except as required for treatment of a speech impairment or speech dysfunction that results from Injury, stroke, cancer, or Congenital Anomaly.
6. Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or stroke.
7. Physiological treatments and procedures that result in the same therapeutic effects when performed on the same body region during the same visit or office encounter.
8. Biofeedback.
9. Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for you because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea.
10. Non-surgical treatment of obesity.
11. Stand-alone multi-disciplinary tobacco cessation programs. These are programs that usually include health care providers specializing in tobacco cessation and may include a psychologist, social worker or other licensed or certified professionals. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.
12. Breast reduction surgery except as coverage is required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services*.
13. Helicobacter pylori (H. pylori) serologic testing.
14. Intracellular micronutrient testing.

## **N. Providers**

1. Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
2. Services performed by a provider with your same legal address.
3. Services provided at a Freestanding Facility or diagnostic Hospital-based Facility without an order written by a Physician or other provider. Services which are self-directed to a Freestanding Facility or diagnostic Hospital-based Facility. Services ordered by a Physician or other provider who is an employee or representative of a Freestanding Facility or diagnostic Hospital-based Facility, when that Physician or other provider:
  - Has not been involved in your medical care prior to ordering the service, or
  - Is not involved in your medical care after the service is received.

This exclusion does not apply to mammography.

## O. Reproduction

1. Health care services and related expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to Benefits as described under *Fertility Preservation for Iatrogenic Infertility and Preimplantation Genetic Testing (PGT) and Related Services* in *Section 1: Covered Health Care Services*.
2. The following services related to a Gestational Carrier or Surrogate:
  - All costs related to reproductive techniques including:
    - ◆ Assisted reproductive technology.
    - ◆ Artificial insemination.
    - ◆ Intrauterine insemination.
    - ◆ Obtaining and transferring embryo(s).
    - ◆ Preimplantation Genetic Testing (PGT) and related services.
  - Health care services including:
    - ◆ Inpatient or outpatient prenatal care and/or preventive care.
    - ◆ Screenings and/or diagnostic testing.
    - ◆ Delivery and post-natal care.

The exclusion for the health care services listed above does not apply when the Gestational Carrier or Surrogate is a Covered Person.
  - All fees including:
    - ◆ Screening, hiring and compensation of a Gestational Carrier or Surrogate including surrogacy agency fees.
    - ◆ Surrogate insurance premiums.
    - ◆ Travel or transportation fees.
3. Costs of donor eggs and donor sperm.
4. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue. This exclusion does not apply to short-term storage (less than one year) and retrieval of reproductive materials for which Benefits are provided as described under *Fertility Preservation for Iatrogenic Infertility and Preimplantation Genetic Testing (PGT) and Related Services* in *Section 1: Covered Health Care Services*.
5. The reversal of voluntary sterilization.
6. In vitro fertilization regardless of the reason for treatment. This exclusion does not apply to in vitro fertilization for which Benefits are provided as described under *Preimplantation Genetic Testing (PGT) and Related Services* in *Section 1: Covered Health Care Services*.

## P. Services Provided under another Plan

1. Health care services for when other coverage is required by federal, state or local law to be bought or provided through other arrangements. Examples include coverage required by workers' compensation, or similar legislation.

If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.
2. Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.

3. Health care services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
4. Health care services during active military duty.

## **Q. Transplants**

1. Health care services for organ and tissue transplants, except those described under *Transplantation Services* in *Section 1: Covered Health Care Services*.
2. Health care services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.)
3. Health care services for transplants involving animal organs.
4. Transplant services not received from a Designated Provider. This exclusion does not apply to cornea transplants.

## **R. Travel**

1. Health care services provided in a foreign country, unless required as Emergency Health Care Services.
2. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Care Services received from a Designated Provider may be paid back as determined by us. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in *Section 1: Covered Health Care Services*.

## **S. Types of Care**

1. Multi-disciplinary pain management programs provided on an inpatient basis for sharp, sudden pain or for worsened long term pain.
2. Custodial Care or maintenance care; except for psychiatric medical institutions for children with Biologically Based Mental Illness.
3. Domiciliary care.
4. Private Duty Nursing is excluded except when required on a home basis as described under *Home Health Care* in *Section 1: Covered Health Care Services*. Private Duty Nursing Services in an Inpatient setting remain excluded. In addition, Benefits for Private Duty Nursing exclude the following:
  - Services provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.
  - Services once patient or caregiver are trained to perform care safely.
  - Services for the comfort or convenience of the Covered Person or the Covered Person's caregiver.
  - Services that are custodial in nature (Custodial Care).
5. Respite care. This exclusion does not apply to respite care for which Benefits are provided as described under *Hospice Care* in *Section 1: Covered Health Care Services*.
6. Rest cures.
7. Services of personal care aides.
8. Work hardening (treatment programs designed to return a person to work or to prepare a person for specific work).

## T. Vision and Hearing

1. Cost and fitting charge for eyeglasses and contact lenses.
2. Routine vision exams, including refractive exams to determine the need for vision correction.
3. Implantable lenses used only to fix a refractive error (such as *Intacs* corneal implants).
4. Eye exercise or vision therapy.
5. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser and other refractive eye surgery.
6. Bone anchored hearing aids except when either of the following applies:
  - You have craniofacial anomalies whose abnormal or absent ear canals prevent the use of a wearable hearing aid.
  - You have hearing loss of sufficient severity that it would not be remedied enough by a wearable hearing aid.

More than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time you are enrolled under the Policy.

Repairs and/or replacement for a bone anchored hearing aid when you meet the above coverage criteria, other than for malfunctions.

## U. All Other Exclusions

1. Health care services and supplies that do not meet the definition of a Covered Health Care Service. Covered Health Care Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:
  - Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
  - Medically Necessary.
  - Described as a Covered Health Care Service in this *Certificate* under *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*.
  - Not otherwise excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.
2. Physical, psychiatric or psychological exams, testing, all forms of vaccinations and immunizations or treatments that are otherwise covered under the Policy when:
  - Required only for school, sports or camp, travel, career or employment, insurance, marriage or adoption.
  - Related to judicial or administrative proceedings or orders. This exclusion does not apply to services that are determined to be Medically Necessary.
  - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Care Services*.
  - Required to get or maintain a license of any type.
3. Health care services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply if you are a civilian injured or otherwise affected by war, any act of war, or terrorism in non-war zones.
4. Health care services received after the date your coverage under the Policy ends. This applies to all health care services, even if the health care service is required to treat a medical condition that started before the date your coverage under the Policy ended.
5. Health care services when you have no legal responsibility to pay, or when a charge would not ordinarily be made in the absence of coverage under the Policy.

6. In the event an out-of-Network provider waives, does not pursue, or fails to collect, Co-payments, Co-insurance and/or any deductible or other amount owed for a particular health care service, no Benefits are provided for the health care service when the Co-payments, Co-insurance and/or deductible are waived.
7. Charges in excess of the Allowed Amount, when applicable, or in excess of any specified limitation.
8. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.
9. Autopsy.
10. Foreign language and sign language interpretation services offered by or required to be provided by a Network or out-of-Network provider.
11. Health care services related to a non-Covered Health Care Service: When a service is not a Covered Health Care Service, all services related to that non-Covered Health Care Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Care Services if the service treats complications that arise from the non-Covered Health Care Service.

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

12. Health care services from an out-of-Network provider for non-emergent, sub-acute inpatient, or outpatient services at any of the following non-Hospital facilities: Alternate Facility, Freestanding Facility, Residential Treatment Facility, Inpatient Rehabilitation Facility, and Skilled Nursing Facility received outside of the Covered Person's state of residence. For the purpose of this exclusion the "state of residence" is the state where the Covered Person is a legal resident, plus any geographically bordering adjacent state or, for a Covered Person who is a student, the state where they attend school during the school year. This exclusion does not apply in the case of an Emergency or if authorization has been obtained in advance.

## Section 3: When Coverage Begins

### How Do You Enroll?

Eligible Persons must complete an enrollment form given to them by the Group. The Group will submit the completed forms to us, along with any required Premium. We will not provide Benefits for health care services that you receive before your effective date of coverage.

### What If You Are Hospitalized When Your Coverage Begins?

We will pay Benefits for Covered Health Care Services when all of the following apply:

- You are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins.
- You receive Covered Health Care Services on or after your first day of coverage related to that Inpatient Stay.
- You receive Covered Health Care Services in accordance with the terms of the Policy.

These Benefits are subject to your previous carrier's obligations under state law or contract.

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

### Who Is Eligible for Coverage?

The Group determines who is eligible to enroll and who qualifies as a Dependent.

#### Eligible Person

Eligible Person usually refers to an employee or member of the Group who meets the eligibility rules. When an Eligible Person enrolls, we refer to that person as a Subscriber. For a complete definition of Eligible Person, Group and Subscriber, see *Section 9: Defined Terms*.

Eligible Persons must live within the United States.

If both spouses are Eligible Persons of the Group, each may enroll as a Subscriber or be covered as an Enrolled Dependent of the other, but not both.

#### Dependent

Dependent generally refers to the Subscriber's spouse and children. When a Dependent enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see *Section 9: Defined Terms*.

Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Policy.

If both parents of a Dependent child are enrolled as a Subscriber, only one parent may enroll the child as a Dependent.

### When Do You Enroll and When Does Coverage Begin?

Except as described below, Eligible Persons may not enroll themselves or their Dependents.

#### Initial Enrollment Period

When the Group purchases coverage under the Policy from us, the Initial Enrollment Period is the first period of time when Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date shown in the Policy. We must receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible.



## Open Enrollment Period

The Group sets the Open Enrollment Period. During the Open Enrollment Period, Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date identified by the Group. We must receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible.

## New Eligible Persons

Coverage for a new Eligible Person and his or her Dependents begins on the date agreed to by the Group. We must receive the completed enrollment form and any required Premium within 31 days of the date the new Eligible Person first becomes eligible.

## Adding New Dependents

Subscribers may enroll Dependents who join their family because of any of the following events:

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- Legal guardianship.
- Court or administrative order.

Coverage for the Dependent begins on the date of the event. We must receive the completed enrollment form and any required Premium within 31 days of the event.

Coverage for newly born children begins from the moment of birth and includes the care and treatment of Congenital Anomalies and birth abnormalities. We must receive notification and any required Premium within 60 days of the event to have coverage continue.

## Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan ended for cause, or because premiums were not paid on a timely basis.

An Eligible Person and/or Dependent does not need to elect COBRA continuation coverage to preserve special enrollment rights. Special enrollment is available to an Eligible Person and/or Dependent even if COBRA is not elected.

A special enrollment period applies to an Eligible Person and any Dependents when one of the following events occurs:

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.

A special enrollment period also applies for an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period if any of the following are true:

- The Eligible Person previously declined coverage under the Policy, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date of determination of subsidy eligibility.
- The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period and coverage under the prior plan ended because of any of the following:

- Loss of eligibility (including legal separation, divorce or death).
- The employer stopped paying the contributions. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer.
- In the case of COBRA continuation coverage, the coverage ended.
- The Eligible Person and/or Dependent no longer resides, lives or works in an HMO service area if no other benefit option is available.
- The plan no longer offers benefits to a class of individuals that includes the Eligible Person and/or Dependent.
- The Eligible Person and/or Dependent loses eligibility under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date coverage ended.

When an event takes place (for example, a birth, marriage or determination of eligibility for state subsidy), coverage begins on the date of the event. We must receive the completed enrollment form and any required Premium within 31 days of the event unless otherwise noted above.

For an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period because they had existing health coverage under another plan, coverage begins on the day following the day coverage under the prior plan ends. Except as otherwise noted above, coverage will begin only if we receive the completed enrollment form and any required Premium within 31 days of the date coverage under the prior plan ended.

## Section 4: When Coverage Ends

### General Information about When Coverage Ends

As permitted by law, we may end the Policy and/or all similar benefit plans at any time for the reasons explained in the Policy.

Your right to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, we will still pay claims for Covered Health Care Services that you received before the date your coverage ended. However, once your coverage ends, we will not pay claims for any health care services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended).

Unless otherwise stated, an Enrolled Dependent's coverage ends on the date the Subscriber's coverage ends.

### What Events End Your Coverage?

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

Your coverage ends on the date the Policy ends. In this event, the Group is responsible for notifying you that your coverage has ended.

- **You Are No Longer Eligible**

Your coverage ends on the date you are no longer eligible to be a Subscriber or Enrolled Dependent. Please refer to *Section 9: Defined Terms* for definitions of the terms "Eligible Person," "Subscriber," "Dependent" and "Enrolled Dependent."

- **We Receive Notice to End Coverage**

The Group is responsible for providing the required notice to us to end your coverage. Your coverage ends on the date we receive the required notice from the Group to end your coverage, or on the date requested in the notice, if later.

- **Subscriber Retires or Is Pensioned**

The Group is responsible for providing the required notice to us to end your coverage. Your coverage ends the date the Subscriber is retired or receiving benefits under the Group's pension or retirement plan.

This provision applies unless there is specific coverage classification for retired or pensioned persons in the Group's *Application*, and only if the Subscriber continues to meet any applicable eligibility requirements. The Group can provide you with specific information about what coverage is available for retirees.

### Fraud or Intentional Misrepresentation of a Material Fact

We will provide at least 30 days advance required notice to the Subscriber that coverage will end on the date we identify in the notice because you committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include knowingly providing incorrect information relating to another person's eligibility or status as a Dependent. You may appeal this decision during the notice period. The notice will contain information on how to appeal the decision.

If we find that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact we have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Policy.

## Extended Coverage for Full-time Students

Coverage for an Enrolled Dependent child who is a Full-time Student at a post-secondary school and who needs a medically necessary leave of absence will be extended until the earlier of the following:

- One year after the medically necessary leave of absence begins.
- The date coverage would otherwise terminate under the Policy.

Coverage will be extended only when the Enrolled Dependent is covered under the Policy because of Full-time Student status at a post-secondary school immediately before the medically necessary leave of absence begins and when the Enrolled Dependent's change in Full-time Student status meets all of the following requirements:

- The Enrolled Dependent is suffering from a serious Sickness or Injury.
- The leave of absence from the post-secondary school is medically necessary, as determined by the Enrolled Dependent's treating Physician.
- The medically necessary leave of absence causes the Enrolled Dependent to lose Full-time Student status for purposes of coverage under the Policy.

A written certification by the treating Physician is required. The certification must state that the Enrolled Dependent child is suffering from a serious Sickness or Injury and that the leave of absence is medically necessary.

For purposes of this extended coverage provision, the term "leave of absence" includes any change in enrollment at the post-secondary school that causes the loss of Full-time Student status.

## Coverage for a Disabled Dependent Child

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

- The Enrolled Dependent child is not able to support him/herself because of mental, developmental, or physical disability.
- The Enrolled Dependent child depends mainly on the Subscriber for support.

Coverage will continue as long as the Enrolled Dependent child is medically certified as disabled and dependent unless coverage otherwise ends in accordance with the terms of the Policy.

You must furnish us with proof of the medical certification of disability within 31 days of the date coverage would have ended because the child reached a certain age. Before we agree to this extension of coverage for the child, we may require that a Physician we choose examine the child. We will pay for that exam.

We may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical exams at our expense. We will not ask for this information more than once a year.

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

## Continuation of Coverage

If your coverage ends under the Policy, you may have the right to elect continuation coverage (coverage that continues on in some form) in accordance with federal or state law.

Continuation coverage under COBRA (the federal Consolidated Omnibus Budget Reconciliation Act) is available only to Groups that are subject to the terms of COBRA. Contact your plan administrator to find out if your Group is subject to the provisions of COBRA.

If you chose continuation coverage under a prior plan which was then replaced by coverage under the Policy, continuation coverage will end as scheduled under the prior plan or in accordance with federal or state law, whichever is earlier.

We are not the Group's designated "plan administrator" as that term is used in federal law, and we do not assume any responsibilities of a "plan administrator" according to federal law.

We are not obligated to provide continuation coverage to you if the Group or its plan administrator fails to

perform its responsibilities under federal law. Examples of the responsibilities of the Group or its plan administrator are:

- Notifying you in a timely manner of the right to elect continuation coverage.
- Notifying us in a timely manner of your election of continuation coverage.

## **Qualifying Events for Continuation Coverage under State Law**

You may request continuation coverage if you or a Dependent lose coverage due to the Subscriber's termination of employment or membership. Continuation coverage is only available if you have been continuously covered under this Policy or another policy that we have replaced for at least three months.

## **Notification Requirements and Election Period for Continuation Coverage under State Law**

The Enrolling Group will provide you with written notification of the right to continuation coverage within 10 days of when coverage ends under the Policy. You must elect continuation coverage within 10 days of receiving this notification or the date coverage ends due to the termination of your employment or membership, whichever is later, as well as pay any required Premium within 31 days of the date the Policy would otherwise end. You should obtain an election form from the Enrolling Group or the employer and, once election is made, forward all monthly Premiums to the Enrolling Group for payment to us.

## **Terminating Events for Continuation Coverage under State Law**

Continuation coverage under the Policy will end on the earliest of the following dates:

- Nine months from the date your continuation began.
- The date coverage ends for failure to make timely payment of the Premium.
- The date coverage ends because you violate a material condition of the Policy.
- The date coverage is or could be obtained under any other group health plan.
- The date coverage ends because you have become eligible for Medicare.
- The date coverage ends because a former spouse remarries, if the Covered Person is a former spouse.
- The date the Enrolling Group terminates participation under the Policy.
- The date the Policy ends.

## Section 5: How to File a Claim

### How Are Covered Health Care Services from Network Providers Paid?

We pay Network providers directly for your Covered Health Care Services. If a Network provider bills you for any Covered Health Care Service, contact us. However, you are required to meet any applicable deductible and to pay any required Co-payments and Co-insurance to a Network provider.

### How Are Covered Health Care Services from an Out-of-Network Provider Paid?

When you receive Covered Health Care Services from an out-of-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described below.

You should submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to us within one year of the date of service, Benefits for that health care service will be denied or reduced, as determined by us. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

#### Required Information

When you request payment of Benefits from us, you must provide us with all of the following information:

- The Subscriber's name and address.
- The patient's name and age.
- The number stated on your ID card.
- The name and address of the provider of the service(s).
- The name and address of any ordering Physician.
- A diagnosis from the Physician.
- An itemized bill from your provider that includes the *Current Procedural Terminology* (CPT) codes or a description of each charge.
- The date the Injury or Sickness began.
- A statement indicating either that you are, or you are not, enrolled for coverage under any other health plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

The above information should be filed with us at the address on your ID card.

When filing a claim for Outpatient Prescription Drug Benefits, your claims should be submitted to:

Optum RX  
PO Box 650629  
Dallas, TX 75265-0629

#### Payment of Benefits

You may not assign your Benefits under the Policy or any cause of action related to your Benefits under the Policy to an out-of-Network provider without our consent. When an assignment is not obtained, we will send the reimbursement directly to the Subscriber for reimbursement to an out-of-Network provider. We may, as we determine, pay an out-of-Network provider directly for services rendered to you. In the case of any such assignment of Benefits or payment to an out-of-Network provider, we have the right to offset Benefits to be paid to the provider by any amounts that the provider owes us.

When you assign your Benefits under the Policy to an out-of-Network provider with our consent, and the out-of-Network provider submits a claim for payment, you and the out-of-Network provider represent and warrant the following:

- The Covered Health Care Services were actually provided.
- The Covered Health Care Services were medically appropriate.

Allowed Amounts due to an out-of-Network provider for Covered Health Care Services that are subject to the *No Surprises Act of the Consolidated Appropriations Act (P.L. 116-260)* are paid directly to the provider.

Payment of Benefits under the Policy shall be in cash or cash equivalents, or in a form of other consideration that we determine to be adequate. Where Benefits are payable directly to a provider, such adequate consideration includes the forgiveness in whole or in part of the amount the provider owes us, or to other plans for which we make payments where we have taken an assignment of the other plans' recovery rights for value.

## Section 6: Questions, Complaints and Appeals

For purposes of this section, the terms below will have the following meanings:

- "Adverse determination" means a determination by us that an admission, availability of care, continued stay, or other health care service, other than a dental care service, that is a Covered Health Care Service has been reviewed and, based upon the information provided, does not meet our requirements for Medically Necessary, appropriateness, health care setting, level of care, effectiveness, and the requested service or payment for the service is therefore denied, reduced, or terminated.
- For the purposes of a denial of a dental care service, "adverse determination" means a determination by us that a dental care service that is a Covered Health Care Service has been reviewed and, based upon the information provided, does not meet our requirements for Medically Necessary, and the requested service or payment for the service is therefore denied, reduced, or terminated in whole or part.
- "Adverse determination" does not include a denial of coverage for a service or treatment specifically listed in the *Certificate of Coverage* as an Exclusion.
- "Final adverse determination" means an adverse determination involving a Covered Health Care Service that has been upheld by us at the completion of our internal grievance process.
- "*Independent Review Organization (IRO)*" means an entity that conducts independent external reviews of adverse determinations and final adverse determinations.

To resolve a question, complaint, or appeal, just follow these steps:

### What if You Have a Question?

Call the telephone number shown on your ID card. Representatives are available to take your call during regular business hours, Monday through Friday.

### What if You Have a Complaint?

Call the telephone number shown on your ID card. Representatives are available to take your call during regular business hours, Monday through Friday.

If you would rather send your complaint to us in writing, the representative can provide you with the address.

If the representative cannot resolve the issue over the phone, he/she can help you prepare and submit a written complaint. We will notify you of our decision regarding your complaint within 60 days of receiving it.

### How Do You Appeal a Claim Decision?

#### Post-service Claims

Post-service claims are claims filed for payment of Benefits after medical care has been received.

#### Pre-service Requests for Benefits

Pre-service requests for Benefits are requests that require prior authorization or benefit confirmation prior to receiving medical care.

#### How to Request an Appeal

If you disagree with a pre-service request for Benefits determination, post-service claim determination, claim involving a surprise medical bill or a rescission of coverage determination, you can contact us in writing to request an appeal.

Your request for an appeal should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.



- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to us within 180 days after you receive the denial of a pre-service request for Benefits or the claim denial.

## Appeal Process

A qualified individual who was not involved in the decision being appealed will be chosen to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with expertise in the field, who was not involved in the prior determination. We may consult with or ask medical experts to take part in the appeal process. You consent to this referral and the sharing of needed medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information related to your claim for Benefits. If any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and in advance of the due date of the response to the adverse benefit determination.

## Appeals Determinations

### Pre-service Requests for Benefits and Post-service Claim Appeals

For procedures related to urgent requests for Benefits, see *Urgent Appeals that Require Immediate Action* below.

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of pre-service requests for Benefits as defined above, the appeal will take place and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied request for Benefits.
- For appeals of post-service claims as defined above, the appeal will take place and you will be notified of the decision within 60 days from receipt of a request for appeal of a denied claim.

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

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

### Urgent Appeals that Require Immediate Action

Your appeal may require urgent action if a delay in treatment could increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.
- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If we need more information from your Physician to make a decision, we will notify you of the decision within 48 hours of receiving that information.

The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

### Exhaustion of Internal Appeal/Grievance Process

You must first exhaust the internal grievance process before requesting an external review, unless:

- You requested a standard internal review of an adverse determination but have not received a written decision from us within 30 business days of filing the request (unless you agreed to a delay).
- We waive the exhaustion of the internal grievance process requirement.
- You have a right to an expedited review prior to a final adverse determination because:

- Your medical condition is such that your life, health, or ability to regain maximum function would be jeopardized under the timeframe for an expedited internal review, final adverse determination, or external review; or
- The adverse determination is based on the service being determined experimental or investigational, and your provider certifies that the service would be significantly less effective if not promptly initiated.

## Standard External Review

You may request an external review in writing within 4 months after receipt of a notice of adverse or final adverse determination. A completed request form and a copy of the written notice must be sent to the Commissioner by personal delivery or mail to: Iowa Insurance Division, 1963 Bell Avenue, Suite 100, Des Moines, Iowa 50315; by facsimile to 515-281-3059; or by email at [iid.marketregulation@iid.iowa.gov](mailto:iid.marketregulation@iid.iowa.gov).

There is no charge or fee for submitting a request for external review. The Commissioner may require us to provide additional time for you to request an external review or submit documentation if we fail to comply with any part of Iowa's external review law or rule chapters.

We will complete a preliminary review of the external review request within 5 business days of receipt to determine whether:

- You were a Covered Person at the time services were requested or provided;
- The services are a Covered Health Care Service, but we had decided they did not meet our requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness;
- You have exhausted the required internal grievance process;
- In the case of Experimental or Investigational Services, there is no treatment that is more effective, medically appropriate, or beneficial for you, as certified by your Physician; and
- You have submitted all required information and forms.

Within 1 business day after completing the preliminary review, we will provide written notice to the Commissioner and you indicating whether the request is complete and eligible for external review. If incomplete, we will notify you of any missing information needed to complete the request. If ineligible, we will explain the reasons for ineligibility for external review and notify you that you may appeal our decision to the Commissioner. The Commissioner is authorized to reverse our initial determination and require that the request be referred for external review.

If eligible for external review, within 1 business day after receiving the written notice of eligibility from us or upon the Commissioner's determination of eligibility, the Commissioner must:

- Assign (on a random basis) a Commissioner-approved *Independent Review Organization (IRO)* and notify us of the IRO's name; and
- Notify you in writing of the request's eligibility and acceptance of external review and of the assigned IRO's name. The notice must also include a statement that you may, within 5 business days of the notice receipt, submit in writing to the assigned IRO any additional information to be considered by the IRO in the review. (The IRO is not required to, but may, accept and consider additional information submitted after 5 business days).

Within 5 business days after receiving the Commissioner's notice of the assigned IRO's name, we will send the IRO any documents and information considered in making the adverse or final adverse determination. If we fail to do so, the IRO may terminate the external review and reverse the adverse or final adverse determination in which case the IRO must notify us, you, and the Commissioner within 1 business day.

In addition to any documents and information provided by us and you, an IRO shall also consider (if available and considered appropriate) medical records, provider recommendations, contract terms, practice guidelines and clinical criteria, and the opinion of the IRO's clinical reviewer.

The IRO must provide written notice of its decision to us, you and the Commissioner within 45 business days after receiving the request for external review.

- The IRO notice must include a general description of the reason for the external review request, the date it was assigned, the time period during which the external review was conducted, the evidence or documentation considered (including evidence-based standards), the date of its decision, and the principal reason(s) for its decision.

- For Experimental or Investigational treatment reviews, the *IRO* notice must also include descriptions of the factors considered by the *IRO* in making its decision.

An *IRO* is not bound by any decisions or conclusions reached in our utilization review, internal grievance or appeals process.

## Expedited External Review

You or your authorized representative may request, orally or in writing, an expedited external review to the Commissioner:

- After receiving a notice of adverse determination from us if:
  - Your medical condition is such that your life, health, or ability to regain maximum function would be jeopardized under the timeframe for an expedited internal review, final adverse determination, or standard external review; or
  - The adverse determination is based on the service being determined experimental or investigational, and your provider certifies that the service would be significantly less effective if not promptly initiated.
- After receiving a notice of final adverse determination from us if:
  - Your medical condition is such that your life, health, or ability to regain maximum function would be jeopardized under the timeframe for a standard external review;
  - The final adverse determination concerns an admission, availability of care, continued stay, or healthcare service for which you received Emergency Health Care Services but have not been discharged from the facility; or
  - The final adverse determination is based on the service being determined experimental or investigational, and your provider certifies that the service would be significantly less effective if not promptly initiated.

Immediately upon receipt of the request, we will determine whether the request meets the following reviewability requirements:

- You were a Covered Person at the time services were requested or provided;
- The services are a Covered Health Care Service, but we decided they did not meet the requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness; and
- In the case of Experimental or Investigational Services, there is no treatment that is more effective, medically appropriate, or beneficial for you, as certified by your Physician.
- You have exhausted the internal grievance process (unless not required to do so).
- You provided all required information and forms.

We will immediately notify you and the Commissioner of our eligibility determination.

If determined ineligible for expedited external review, we will also notify you that you may appeal our decision to the Commissioner.

The Commissioner is authorized to reverse our determination of ineligibility and require that the request be referred for external review.

If eligible for expedited external review, immediately upon receiving written notice of eligibility from us or upon the Commissioner's determination of eligibility, the Commissioner will:

- Assign (on a random basis) a Commissioner-approved *Independent Review Organization (IRO)* and notify us and you of the *IRO*'s name; and
- Upon receipt of the Commissioner's notice of the *IRO* name, we will provide or transmit (electronically, by telephone, facsimile or any other available expeditious method) to the assigned *IRO* all necessary documents and information considered in making the adverse or final adverse determination.
- In addition to any documents and information provided by us and you, an *IRO* shall also consider (if available and considered appropriate) medical records, provider recommendations, contract terms, practice guidelines and clinical criteria, and the opinion of the *IRO*'s clinical reviewer.

In reaching a decision, the *IRO* is not bound by any decisions or conclusions reached in our utilization review or internal grievance process.

The *IRO* must reach a decision and notify us, you and the Commissioner as expeditiously as possible, but in no event more than 72 hours after the date of receipt of the request for an expedited external review. If the initial notice is provided orally, then within 48 hours after the date of providing the initial notice, the assigned *IRO* will provide written confirmation of the decision to you, us and the Commissioner.

The *IRO* must include in the written notice the following information:

- A general description of the reason for the external review request, the date it was assigned by the Commissioner, the date the external review was conducted, the date of its decision, the principal reason/s for its decision, the rationale for its decision, and references to the evidence or documentation considered (including evidence-based standards).
- For Experimental or Investigational treatment reviews, descriptions of the factors considered by the *IRO* in making its decision.

## **Independent Review Organization (IRO)**

All decisions by the *IRO* are deemed as binding on us, and on you except to the extent that you have other remedies available under applicable federal or state law.

We will approve coverage if the *IRO* reverses the final adverse decision.

## Section 7: Coordination of Benefits

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

This section describes how Benefits under the Policy will be coordinated with those of any other plan that provides benefits to you. The language in this section is from model laws drafted by the *National Association of Insurance Commissioners (NAIC)* and represents standard industry practice for coordinating benefits.

### When Does Coordination of Benefits Apply?

This Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

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

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

### Definitions

For purposes of this section, terms are defined as follows:

- A. **Plan.** A Plan is any of the following that provides benefits or services for medical, pharmacy or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
1. Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
  2. Plan does not include: hospital indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

- B. **This Plan.** This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.
- C. **Order of Benefit Determination Rules.** The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.
- D. **Allowable Expense.** Allowable Expense is a health care expense, including deductibles, co-insurance and co-payments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable

Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or according to contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense.

The following are examples of expenses or services that are not Allowable Expenses:

1. The difference between the cost of a semi-private hospital room and a private room is not an Allowable Expense unless one of the Plans provides coverage for private hospital room expenses.
  2. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
  3. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
  4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.
  5. The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions and preferred provider arrangements.
- E. **Closed Panel Plan.** Closed Panel Plan is a Plan that provides health care benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.
- F. **Custodial Parent.** Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

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

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

- A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.
- B. Except as provided in the next paragraph, a Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary unless the provisions of both Plans state that the complying plan is primary.

Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be in excess of any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

- C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.
- D. Each Plan determines its order of benefits using the first of the following rules that apply:

1. **Non-Dependent or Dependent.** The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.
2. **Dependent Child Covered Under More Than One Coverage Plan.** Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:
  - a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
    - (1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
    - (2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.
  - b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:
    - (1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary Plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.
    - (2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.
    - (3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.
    - (4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:
      - (a) The Plan covering the Custodial Parent.
      - (b) The Plan covering the Custodial Parent's spouse.
      - (c) The Plan covering the non-Custodial Parent.
      - (d) The Plan covering the non-Custodial Parent's spouse.
  - c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.
  - d) (i) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in paragraph (5) applies.  
  
(ii) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in subparagraph (a) to the dependent child's parent(s) and the dependent's spouse.

3. **Active Employee or Retired or Laid-off Employee.** The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.
4. **COBRA or State Continuation Coverage.** If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.
5. **Longer or Shorter Length of Coverage.** The Plan that covered the person the longer period of time is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.
6. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

## Effect on the Benefits of This Plan

- A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.
- B. If a Covered Person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

## Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts we need from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits.

We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give us any facts we need to apply those rules and determine benefits payable. If you do not provide us the information we need to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

## Payments Made

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, we may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.



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

If the amount of the payments we made is more than we should have paid under this COB provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or services provided for you. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

## **How Are Benefits Paid When This Plan is Secondary to Medicare?**

If This Plan is secondary to Medicare, then Benefits payable under This Plan will be based on Medicare's reduced benefits.

## Section 8: General Legal Provisions

### What Is Your Relationship with Us?

It is important for you to understand our role with respect to the Group's Policy and how it may affect you. We help finance or administer the Group's Policy in which you are enrolled. We do not provide medical services or make treatment decisions. This means:

- We communicate to you decisions about whether the Group's Policy will cover or pay for the health care that you may receive. The Policy pays for Covered Health Care Services, which are more fully described in this *Certificate*.
- The Policy may not pay for all treatments you or your Physician may believe are needed. If the Policy does not pay, you will be responsible for the cost.

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

Please refer to our *Notice of Privacy Practices* for details.

### What Is Our Relationship with Providers and Groups?

We have agreements in place that govern the relationship between us, our Groups and Network providers, some of which are affiliated providers. Network providers enter into agreements with us to provide Covered Health Care Services to Covered Persons.

We do not provide health care services or supplies, or practice medicine. We arrange for health care providers to participate in a Network and we pay Benefits. Network providers are independent practitioners who run their own offices and facilities. Our credentialing process confirms public information about the providers' licenses and other credentials. It does not assure the quality of the services provided. We are not responsible for any act or omission of any provider.

We are not considered to be an employer for any purpose with respect to the administration or provision of benefits under the Group's Policy. We are not responsible for fulfilling any duties or obligations of an employer with respect to the Group's Policy.

The Group is solely responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of the Policy Charge to us.
- Notifying you of when the Policy ends.

When the Group purchases the Policy to provide coverage under a benefit plan governed by the *Employee Retirement Income Security Act* ("ERISA"), 29 U.S.C. §1001 et seq., we are not the plan administrator or named fiduciary of the benefit plan, as those terms are used in ERISA. If you have questions about your welfare benefit plan, you should contact the Group. If you have any questions about this statement or about your rights under ERISA, contact the nearest area office of the *Employee Benefits Security Administration, U. S. Department of Labor*.

### What Is Your Relationship with Providers and Groups?

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

You are responsible for all of the following:

- Choosing your own provider.
- Paying, directly to your provider, any amount identified as a member responsibility, including Co-payments, Co-insurance, any deductible and any amount that exceeds the Allowed Amount, when applicable.
- Paying, directly to your provider, the cost of any non-Covered Health Care Service.

- Deciding if any provider treating you is right for you. This includes Network providers you choose and providers that they refer.
- Deciding with your provider what care you should receive.

Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and the Group is that of employer and employee, Dependent or other classification as defined in the Policy.

## Notice

When we provide written notice regarding administration of the Policy to an authorized representative of the Group, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Group is responsible for giving notice to you.

## Statements by Group or Subscriber

All statements made by the Group or by a Subscriber shall, in the absence of fraud, be deemed representations and not warranties. We will not use any statement made by the Group to void the Policy after it has been in force for two years unless it is a fraudulent statement.

## Do We Pay Incentives to Providers?

We pay Network providers through various types of contractual arrangements. Some of these arrangements may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction and/or cost-effectiveness.
- Capitation - a group of Network providers receives a monthly payment from us for each Covered Person who selects a Network provider within the group to perform or coordinate certain health care services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.
- Bundled payments - certain Network providers receive a bundled payment for a group of Covered Health Care Services for a particular procedure or medical condition. The applicable Co-payment and/or Co-insurance will be calculated based on the provider type that received the bundled payment. The Network providers receive these bundled payments regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment. If you receive follow-up services related to a procedure where a bundled payment is made, an additional Co-payment and/or Co-insurance may not be required if such follow-up services are included in the bundled payment. You may receive some Covered Health Care Services that are not considered part of the inclusive bundled payment and those Covered Health Care Services would be subject to the applicable Co-payment and/or Co-insurance as described in the *Schedule of Benefits*.

We use various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with us includes any financial incentives, we encourage you to discuss those questions with your provider. You may also call us at the telephone number on your ID card. We can advise whether your Network provider is paid by any financial incentive, including those listed above.

## Are Incentives Available to You?

Sometimes we may offer coupons, enhanced Benefits, or other incentives to encourage you to take part in various programs, including wellness programs, certain disease management programs, surveys, discount programs and/or programs to seek care in a more cost effective setting and/or from Designated Providers. In some instances, these programs may be offered in combination with a non-UnitedHealthcare entity. The decision about whether or not to take part in a program is yours alone. However, we recommend that you discuss taking part in such programs with your Physician. Contact us at [www.myuhc.com](http://www.myuhc.com) or the telephone number on your ID card if you have any questions.

## Do We Receive Rebates and Other Payments?

We may receive rebates for certain drugs that are administered to you in your home or in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet any applicable deductible. As determined by us, we may pass a portion of these rebates on to you. When rebates are passed onto you, they may be taken into account in determining your Co-payment and/or Co-insurance.

## Who Interprets Benefits and Other Provisions under the Policy?

We have the final authority to do all of the following:

- Interpret Benefits under the Policy.
- Interpret the other terms, conditions, limitations and exclusions set out in the Policy, including this *Certificate*, the *Schedule of Benefits* and any Riders and/or Amendments.
- Make factual determinations related to the Policy and its Benefits.

We may assign this authority to other persons or entities that provide services in regard to the administration of the Policy.

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

## Who Provides Administrative Services?

We provide administrative services or, as we determine, we may arrange for various persons or entities to provide administrative services, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time as we determine. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

## Amendments to the Policy

To the extent permitted by law, we have the right, as we determine and without your approval, to change, interpret, withdraw or add Benefits or end the Policy.

Any provision of the Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which the Policy is delivered) is amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to the Policy unless it is made by an Amendment or Rider which has been signed by one of our officers and consistent with applicable notice requirements. All of the following conditions apply:

- Amendments and Riders to the Policy are effective upon the Group's next anniversary date, except as otherwise permitted by law.
- No agent has the authority to change the Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to the Policy.

## How Do We Use Information and Records?

We may use your individually identifiable health information as follows:

- To administer the Policy and pay claims.
- To identify procedures, products, or services that you may find valuable.
- As otherwise permitted or required by law.

We may request additional information from you to decide your claim for Benefits. We will keep this information confidential. We may also use de-identified data for commercial purposes, including research, as permitted by law. More detail about how we may use or disclose your information is found in our *Notice of Privacy Practices*.

By accepting Benefits under the Policy, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to the services provided to you. We

have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form. We agree that such information and records will be considered confidential.

We have the right to release records concerning health care services when any of the following apply:

- Needed to put in place and administer the terms of the Policy.
- Needed for medical review or quality assessment.
- Required by law or regulation.

During and after the term of the Policy, we and our related entities may use and transfer the information gathered under the Policy in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to our *Notice of Privacy Practices*.

For complete listings of your medical records or billing statements you may contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, we will designate other persons or entities to request records or information from or related to you, and to release those records as needed. Our designees have the same rights to this information as we have.

## **Do We Require Examination of Covered Persons?**

In the event of a question or dispute regarding your right to Benefits, we may require that a Network Physician of our choice examine you at our expense.

## **Is Workers' Compensation Affected?**

Benefits provided under the Policy do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

## **Subrogation and Reimbursement**

We have the right to subrogation and reimbursement. References to "you" or "your" in this *Subrogation and Reimbursement* section shall include you, your Estate and your heirs and beneficiaries unless otherwise stated.

Subrogation applies when we have paid Benefits on your behalf for a Sickness or Injury for which any third party is allegedly responsible. The right to subrogation means that we are substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the Benefits that we have paid that are related to the Sickness or Injury for which any third party is considered responsible.

*Subrogation Example:*

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

The right to reimbursement means that if it is alleged that any third party caused or is responsible for a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to us 100% of any Benefits you receive for that Sickness or Injury. The right of reimbursement shall apply to any benefits received at any time until the rights are extinguished, resolved or waived in writing.

*Reimbursement Example:*

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

The following persons and entities are considered third parties:

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

You agree as follows:

- You will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - Notifying us, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable.
  - Providing any relevant information requested by us.
  - Signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or injuries.
  - Making court appearances.
  - Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
  - Complying with the terms of this section.

Your failure to cooperate with us is considered a breach of contract. As such, we have the right to terminate or deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits we have paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by us due to you or your representative not cooperating with us. If we incur attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, we have the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to us.

- We have a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, our first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- Our subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your Estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. We are not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from our recovery without our express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- Regardless of whether you have been fully compensated or made whole, we may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which we may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or

"Make-Whole Doctrine", claim of unjust enrichment, nor any other equitable limitation shall limit our subrogation and reimbursement rights.

- Benefits paid by us may also be considered to be Benefits advanced.
- If you receive any payment from any party as a result of Sickness or Injury, and we allege some or all of those funds are due and owed to us, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
- By participating in and accepting Benefits under the Policy, you agree that (i) any amounts recovered by you from any third party shall constitute Policy assets (to the extent of the amount of Benefits provided on behalf of the Covered Person), (ii) you and your representative shall be fiduciaries of the Policy (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by us to enforce its reimbursement rights.
- Our right to recovery will not be reduced due to your own negligence.
- By participating in and accepting Benefits from us, you agree to assign to us any benefits, claims or rights of recovery you have under any automobile policy - including no-fault benefits, PIP benefits and/or medical payment benefits - other coverage or against any third party, to the full extent of the Benefits we have paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting benefits, you acknowledge and recognize our right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.
- We may, at our option, take necessary and appropriate action to preserve our rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical benefits you receive for the Sickness or Injury out of any settlement, judgment or other recovery from any third party considered responsible; and filing suit in your name or your Estate's name, which does not obligate us in any way to pay you part of any recovery we might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund Benefits as required under the terms of the Policy is governed by a six-year statute of limitations.
- You may not accept any settlement that does not fully reimburse us, without our written approval.
- We have the final authority to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death our right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse us is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse us for 100% of our interest unless we provide written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If any third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under the Policy, the provisions of this section continue to apply, even after you are no longer covered.
- In the event that you do not abide by the terms of the Policy pertaining to reimbursement, we may terminate Benefits to you, your dependents or the subscriber, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits we have paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by us due to your failure to abide by the terms of the Policy. If we incur attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, we have the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to us.
- We and all Administrators administering the terms and conditions of the Policy's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of our final authority to (1) construe and enforce the terms of the Policy's subrogation

and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to us.

## **When Do We Receive Refunds of Overpayments?**

If we pay Benefits for expenses incurred on your account, you, or any other person or organization that was paid, must make a refund to us if any of the following apply:

- All or some of the expenses were not paid or did not legally have to be paid by you.
- All or some of the payment we made exceeded the Benefits under the Policy.
- All or some of the payment was made in error.

The refund equals the amount we paid in excess of the amount we should have paid under the Policy. If the refund is due from another person or organization, you agree to help us get the refund when requested.

If the refund is due from you and you do not promptly refund the full amount, we may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, your future Benefits that are payable under the Policy. If the refund is due from a person or organization other than you, we may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part; (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Policy; or (ii) future Benefits that are payable in connection with services provided to persons under other plans for which we make payments, pursuant to a transaction in which our overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment.

The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

## **Is There a Limitation of Action?**

You cannot bring any legal action against us to recover reimbursement until you have completed all the steps in the appeal process described in *Section 6: Questions, Complaints and Appeals*. After completing that process, if you want to bring a legal action against us you must do so within three years of the date we notified you of our final decision on your appeal or you lose any rights to bring such an action against us.

## **What Is the Entire Policy?**

The Policy, this *Certificate*, the *Schedule of Benefits*, the Group's *Application* and any Riders and/or Amendments, make up the entire Policy that is issued to the Group.



## Section 9: Defined Terms

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

**Allowed Amounts** - for Covered Health Care Services, incurred while the Policy is in effect, Allowed Amounts are determined by us or determined as required by law as shown in the *Schedule of Benefits*.

Allowed Amounts are determined in accordance with our reimbursement policy guidelines or as required by law. We develop these guidelines, as we determine, after review of all provider billings in accordance with one or more of the following methodologies:

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

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

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

It may also provide Mental Health Care Services or Substance-Related and Addictive Disorders Services on an outpatient or inpatient basis.

**Amendment** - any attached written description of added or changed provisions to the Policy. It is effective only when signed by us. It is subject to all conditions, limitations and exclusions of the Policy, except for those that are specifically amended.

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

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

**Annual Deductible** - the total of the Allowed Amount or the Recognized Amount when applicable, you must pay for Covered Health Care Services per year before we will begin paying for Benefits. It does not include any amount that exceeds Allowed Amounts or Recognized Amounts when applicable. The *Schedule of Benefits* will tell you if your plan is subject to payment of an Annual Deductible and how it applies.

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

**Benefits** - your right to payment for Covered Health Care Services that are available under the Policy.

**Biologically Based Mental Illness** - the following psychiatric illnesses: schizophrenia, bipolar disorders, major depressive disorders, schizo-affective disorders, obsessive-compulsive disorders, pervasive developmental disorders and autistic disorders.

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

**Co-insurance** - the charge, stated as a percentage of the Allowed Amount or the Recognized Amount when applicable, that you are required to pay for certain Covered Health Care Services.

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

**Co-payment** - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Care Services.

Please note that for Covered Health Care Services, you are responsible for paying the lesser of the following:

- The Co-payment.
- The Allowed Amount or the Recognized Amount when applicable.

**Cosmetic Procedures** - procedures or services that change or improve appearance without significantly improving physiological function.

**Covered Health Care Service(s)** - health care services, including supplies or Pharmaceutical Products, which we determine to be all of the following:

- Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
- Medically Necessary.
- Described as a Covered Health Care Service in this *Certificate* under *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*.
- Not excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.

**Covered Person** - the Subscriber or a Dependent, but this term applies only while the person is enrolled under the Policy. We use "you" and "your" in this *Certificate* to refer to a Covered Person.

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

- Non health-related services such as help with daily living activities. Examples include eating, dressing, bathing, transferring and ambulating.
- Health-related services that can safely and effectively be performed by trained non-medical personnel and are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function, as opposed to improving that function to an extent that might allow for a more independent existence.

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

**Dependent** - the Subscriber's legal spouse or a child of the Subscriber or the Subscriber's spouse. As described in *Section 3: When Coverage Begins*, the Group determines who is eligible to enroll and who qualifies as a Dependent. The term "child" includes:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.
- A child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. The Group is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order*.

The following conditions apply:

- A Dependent includes a child listed above under age 26.
- A Dependent includes an unmarried dependent child who is 26 years of age or older, if you furnish evidence upon our request, satisfactory to us that the unmarried Dependent child maintains a full-time status as a student in an accredited institution of postsecondary education.
- A child is no longer eligible as a Dependent on the last day of the month following the date the child reaches age 26 except as provided in *Section 4: When Coverage Ends* under *Coverage for a Disabled Dependent Child*.

- A child who meets the requirements set forth above ceases to be eligible as a Dependent on the last day of the month following the date the child reaches the limiting age as described above.

The Subscriber must reimburse us for any Benefits paid during a time a child did not satisfy these conditions.

A Dependent does not include anyone who is also enrolled as a Subscriber. No one can be a Dependent of more than one Subscriber.

**Designated Diagnostic Provider** - a provider and/or facility that we have identified through our designation programs as a Designated Diagnostic Provider.

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

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

**Designated Provider** - a provider and/or facility that:

- Has entered into an agreement with us, or with an organization contracting on our behalf, to provide Covered Health Care Service for the treatment of specific diseases or conditions; or
- We have identified through our designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures.

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

You can find out if your provider is a Designated Provider by contacting us at [www.myuhc.com](http://www.myuhc.com) or the telephone number on your ID card.

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

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

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered DME.
- Not of use to a person in the absence of a disease or disability.
- Serves a medical purpose for the treatment of a Sickness or Injury.
- Primarily used within the home.

**Eligible Person** - an employee of the Group or other person connected to the Group who meets the eligibility requirements shown in both the Group's *Application* and the Policy. An Eligible Person must live within the United States.

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

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

**Emergency Health Care Services** - with respect to an Emergency:

- An appropriate medical screening exam (as required under section 1867 of the *Social Security Act* or as would be required under such section if such section applied to an Independent Freestanding Emergency Department) that is within the capability of the emergency department of a Hospital, or an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency, and

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

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

**Enrolled Dependent** - a Dependent who is properly enrolled under the Policy.

**Experimental or Investigational Service(s)** - medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following:

1. Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified as appropriate for proposed use in any of the following:
  - *AHFS Drug Information (AHFS DI)* under therapeutic uses section;
  - *Elsevier Gold Standard's Clinical Pharmacology* under the indications section;
  - *DRUGDEX System by Micromedex* under the therapeutic uses section and has a strength recommendation rating of class I, class IIa, or class IIb; or
  - *National Comprehensive Cancer Network (NCCN)* drugs and biologics compendium category of evidence 1, 2A, or 2B.
2. Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not Experimental or Investigational.)
3. The subject of an ongoing clinical trial that meets the definition of a Phase I, II, or III clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.
4. Only obtainable, with regard to outcomes for the given indication, within research settings.

Exceptions:

- Clinical trials for which Benefits are available as described under *Clinical Trials* in *Section 1: Covered Health Care Services*.

- We may, as we determine, consider an otherwise Experimental or Investigational Service to be a Covered Health Care Service for that Sickness or condition if:
  - You are not a participant in a qualifying clinical trial, as described under *Clinical Trials* in *Section 1: Covered Health Care Services*; and
  - You have a Sickness or condition that is likely to cause death within one year of the request for treatment.

Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition.

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

**Full-time Student** - a person who is enrolled in and attending, full-time, a recognized course of study or training at one of the following:

- An accredited high school.
- An accredited college or university.
- A licensed vocational school, technical school, cosmetology school, automotive school or similar training school.
- Full-time Student status is determined in accordance with the standards set forth by the educational institution. You are no longer a Full-time Student at the end of the calendar month during which on the date you graduate or otherwise cease to be enrolled and in attendance at the institution on a full-time basis.
- You continue to be a Full-time Student during periods of regular vacation established by the institution. If you do not continue as a Full-time Student immediately following the period of vacation, the Full-time Student designation will end as described above.

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

**Genetic Counseling** - counseling by a qualified clinician that includes:

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

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

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

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

**Group** - the employer, or other defined or otherwise legally established group, to whom the Policy is issued.

**Home Health Agency** - a program or organization authorized by law to provide health care services in the home.

**Hospital** - an institution that is operated as required by law and that meets both of the following:

- It is mainly engaged in providing inpatient health care services, for the short term care and treatment of injured or sick persons. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

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

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

**Iatrogenic Infertility** - an impairment of fertility by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes.

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

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

**Initial Enrollment Period** - the first period of time when Eligible Persons may enroll themselves and their Dependents under the Policy.

**Injury** - damage to the body, including all related conditions and symptoms.

**Inpatient Rehabilitation Facility** - any of the following that provides inpatient rehabilitation health care services (including physical therapy, occupational therapy and/or speech therapy), as authorized by law:

- A long term acute rehabilitation center,
- A Hospital, or
- A special unit of a Hospital designated as an Inpatient Rehabilitation Facility.

**Inpatient Stay** - a continuous stay that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

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

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

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

**Intermittent Care** - skilled nursing care that is provided either:

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

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

**Manipulative Treatment (adjustment)** - a form of care provided by chiropractors and osteopaths for diagnosed muscle, nerve and joint problems. Body parts are moved either by hands or by a small instrument to:

- Restore or improve motion.
- Reduce pain.
- Increase function.

**Medically Necessary** - health care services that are all of the following as determined by us or our designee:

- In accordance with *Generally Accepted Standards of Medical Practice*.
- Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

*Generally Accepted Standards of Medical Practice* are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying

primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We have the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be determined by us.

We develop and maintain clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revised from time to time), are available to Covered Persons through [www.myuhc.com](http://www.myuhc.com) or the telephone number on your ID card. They are also available to Physicians and other health care professionals on [UHCprovider.com](http://UHCprovider.com).

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

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

**Mental Health/Substance-Related and Addictive Disorders Designee** - the organization or individual, designated by us, that provides or arranges Mental Health Care Services and Substance-Related and Addictive Disorders Services. This does not include Biologically Based Mental Illness.

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

**Network** - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with us or with our affiliate to participate in our Network. This does not include those providers who have agreed to discount their charges for Covered Health Care Services. Our affiliates are those entities affiliated with us through common ownership or control with us or with our ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Care Services, but not all Covered Health Care Services, or to be a Network provider for only some of our products. In this case, the provider will be a Network provider for the Covered Health Care Services and products included in the participation agreement and an out-of-Network provider for other Covered Health Care Services and products. The participation status of providers will change from time to time.

**Network Benefits** - the description of how Benefits are paid for Covered Health Care Services provided by Network providers. The *Schedule of Benefits* will tell you if your plan offers Network Benefits and how Network Benefits apply.

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

- The date as determined by us or our designee, which is based on when the Pharmaceutical Product is reviewed and when utilization management strategies are implemented.
- December 31st of the following calendar year.

**Non-Medical 24-Hour Withdrawal Management** - an organized residential service, including those defined in the *American Society of Addiction Medicine (ASAM) Criteria*, providing 24-hour supervision, observation, and

support for patients who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care.

**Open Enrollment Period** - a period of time, after the Initial Enrollment Period, when Eligible Persons may enroll themselves and Dependents under the Policy. The Group sets the period of time that is the Open Enrollment Period.

**Out-of-Network Benefits** - the description of how Benefits are paid for Covered Health Care Services provided by out-of-Network providers. The *Schedule of Benefits* will tell you if your plan offers Out-of-Network Benefits and how Out-of-Network Benefits apply.

**Out-of-Pocket Limit** - the maximum amount you pay every year. The *Schedule of Benefits* will tell you how the Out-of-Pocket Limit applies.

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

**Per Occurrence Deductible** - the portion of the Allowed Amount or the Recognized Amount when applicable, (stated as a set dollar amount) that you must pay for certain Covered Health Care Services prior to, and in addition to, any Annual Deductible before we begin paying Benefits for those Covered Health Care Services.

When a plan has a Per Occurrence Deductible, you are responsible for paying the lesser of the following:

- The applicable Per Occurrence Deductible.
- The Allowed Amount or the Recognized Amount when applicable.

The *Schedule of Benefits* will tell you if your plan is subject to payment of a Per Occurrence Deductible and how the Per Occurrence Deductible applies.

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

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

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, licensed physician assistant, licensed advanced registered nurse, physical therapist, osteopathic physician, registered nurse or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Policy.

**Policy** - the entire agreement issued to the Group that includes all of the following:

- *Group Policy.*
- *Certificate.*
- *Schedule of Benefits.*
- *Group Application.*
- *Riders.*
- *Amendments.*

These documents make up the entire agreement that is issued to the Group.

**Policy Charge** - the sum of the Premiums for all Covered Persons enrolled under the Policy.

**Pregnancy** - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

**Preimplantation Genetic Testing (PGT)** - a test performed to analyze the DNA from oocytes or embryos for human leukocyte antigen (HLA) typing or for determining genetic abnormalities. These include:

- PGT-M - for monogenic disorder (formerly single-gene PGD).
- PGT-SR - for structural rearrangements (formerly chromosomal PGD).



**Premium** - the periodic fee required for each Subscriber and each Enrolled Dependent, in accordance with the terms of the Policy.

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

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

**Private Duty Nursing** - nursing services for Covered Persons who require more individual and continuous care in the home than is available from a visiting nurse through a Home Health Agency. Rather than a nursing service that is 4 hours or less and periodic (and for which Benefits are provided under *Home Health Care* in the *Certificate and Schedule of Benefits*), the Private Duty Nursing services are provided where longer durations of skilled nursing care for complex medical conditions requiring immediate medical interventions are required and may include shift care or 24/7 continuous cares in certain settings.

**Recognized Amount** - the amount which Co-payment, Co-insurance and applicable deductible, is based on for the below Covered Health Care Services when provided by out-of-Network providers:

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

The amount is based on one of the following in the order listed below as applicable:

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

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

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

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

**Residential Treatment** - treatment in a facility established and operated as required by law, which provides Mental Health Care Services or Substance-Related and Addictive Disorders Services. It must meet all of the following requirements:

- Provides a program of treatment, approved by the Mental Health/Substance-Related and Addictive Disorders Designee, under the active participation and direction of a Physician and, approved by the Mental Health/Substance-Related and Addictive Disorder Designee.

- Offers organized treatment services that feature a planned and structured regimen of care in a 24-hour setting and provides at least the following basic services:
  - Room and board.
  - Evaluation and diagnosis.
  - Counseling.
  - Referral and orientation to specialized community resources.

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

**Rider** - any attached written description of additional Covered Health Care Services not described in this *Certificate*. Covered Health Care Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended in the Rider.

**Secretary** - the Secretary of Health and Human Services, the Secretary of Labor, and/or the Secretary of Treasury, according to the *No Surprises Act of the Consolidated Appropriations Act (P.L. 116-260)*.

**Semi-private Room** - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Care Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is Medically Necessary, or when a Semi-private Room is not available.

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

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

- Must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- Ordered by a Physician.
- Not delivered for the purpose of helping with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- Requires clinical training in order to be delivered safely and effectively.
- Not Custodial Care, which can safely and effectively be performed by trained non-medical personnel.

**Skilled Nursing Facility** - a Hospital or nursing facility that is licensed and operated as required by law.

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

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

**Subscriber** - an Eligible Person who is properly enrolled under the Policy. The Subscriber is the person (who is not a Dependent) on whose behalf the Policy is issued to the Group.

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

**Surrogate** - a female who becomes pregnant usually by artificial insemination or transfer of a fertilized egg (embryo) for the purpose of carrying the fetus for another person.

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

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. They provide stable and safe housing, an alcohol/drug-free environment and support for recovery. They may be used as an

addition to ambulatory treatment when it doesn't offer the intensity and structure needed to help you with recovery.

- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments. They provide stable and safe housing and the opportunity to learn how to manage activities of daily living. They may be used as an addition to treatment when it doesn't offer the intensity and structure needed to help you with recovery.

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

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

We have a process by which we compile and review clinical evidence with respect to certain health care services. From time to time, we issue medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at [www.myuhc.com](http://www.myuhc.com).

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, as we determine, consider an otherwise Unproven Service to be a Covered Health Care Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition.

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

## Section 10: Outpatient Prescription Drug Products

This section describes Prescription Drug Products for which Benefits are available. Please refer to the *Outpatient Prescription Drug Schedule of Benefits* for additional payment details.

NOTE: The Coordination of Benefits provision in the *Certificate* in *Section 7: Coordination of Benefits* applies to Prescription Drug Products covered through this section. Benefits for Prescription Drug Products will be coordinated with those of any other health plan in the same manner as Benefits for Covered Health Care Services described in *Section 1: Covered Health Care Services*.

### Coverage Policies and Guidelines

Our Prescription Drug List (PDL) Management Committee makes tier placement changes on our behalf. The PDL Management Committee places FDA-approved Prescription Drug Product into tiers by considering a number of factors including clinical and economic factors. Clinical factors may include review of the place in therapy or use as compared to other similar product or services, site of care, relative safety or effectiveness of the Prescription Drug Product, as well as if certain supply limits or prior authorization requirements should apply. Economic factors may include the Prescription Drug Product's total cost including any rebates and evaluations of the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are more cost effective for treating specific conditions as compared to others; therefore, a Prescription Drug Product may be placed on multiple tiers according to the condition for which the Prescription Drug Product was prescribed to treat, or according to whether it was prescribed by a Specialist.

We may, from time to time, change the placement of a Prescription Drug Product among the tiers. These changes generally will happen quarterly, but no more than six times per calendar year. These changes may happen without prior notice to you.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for you is a determination that is made by you and your prescribing Physician.

NOTE: The tier placement of a Prescription Drug Product may change, from time to time, based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please contact us at [www.myuhc.com](http://www.myuhc.com) or the telephone number on your ID card for the most up-to-date tier placement.

### Identification Card (ID Card) - Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by us during regular business hours.

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you must pay the Usual and Customary Charge for the Prescription Drug Product at the pharmacy.

You may seek reimbursement from us as described in the *Certificate* in *Section 5: How to File a Claim*. When you submit a claim on this basis, you may pay more because you did not verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Co-payment and/or Co-insurance, Ancillary Charge, and any deductible that applies.

Submit your claim to:

Optum Rx  
PO Box 650629  
Dallas, TX 75265-0629

## Designated Pharmacies

If you require certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products. If you choose not to obtain your Prescription Drug Product from the Designated Pharmacy, you may opt-out of the Designated Pharmacy program by contacting us at [www.myuhc.com](http://www.myuhc.com) or the telephone number on your ID card. If you want to opt-out of the program and fill your Prescription Drug Product at a non-Designated Pharmacy but do not inform us, you will be responsible for the entire cost of the Prescription Drug Product and no Benefits will be paid.

If you are directed to a Designated Pharmacy and you have informed us of your decision not to obtain your Prescription Drug Product from a Designated Pharmacy, you will be subject to the out-of-Network Benefit for that Prescription Drug Product. For a Specialty Prescription Drug Product, if you choose to obtain your Specialty Prescription Drug Product at a Non-Preferred Specialty Network Pharmacy, you will be subject to the Non-Preferred Specialty Network Co-payment and/or Co-insurance.

### *Smart Fill Program - Split Fill*

Certain Specialty Prescription Drug Products may be dispensed by the Designated Pharmacy in 15-day supplies up to 90 days and at a pro-rated Co-payment or Co-insurance. You will receive a 15-day supply of their Specialty Prescription Drug Product to find out if you will tolerate the Specialty Prescription Drug Product prior to purchasing a full supply. The Designated Pharmacy will contact you each time prior to dispensing the 15-day supply to confirm if you are tolerating the Specialty Prescription Drug Product. You may find a list of Specialty Prescription Drug Products included in the *Smart Fill Program*, by contacting us at [www.myuhc.com](http://www.myuhc.com) or the telephone number on your ID card.

### *Smart Fill Program - 90-Day Supply*

Certain Specialty Prescription Drug Products may be dispensed by the Designated Pharmacy in 90-day supplies. The Co-payment and/or Co-insurance will reflect the number of days dispensed. The *Smart Fill Program* offers a 90-day supply of certain Specialty Prescription Drug Products if you are stabilized on a Specialty Prescription Drug Product included in the *Smart Fill Program*. You may find a list of Specialty Prescription Drug Products included in the Smart Fill Program, by contacting us at [www.myuhc.com](http://www.myuhc.com) or the telephone number on your ID card.

## When Do We Limit Selection of Pharmacies?

If we determine that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your choice of Network Pharmacies may be limited. If this happens, we may require you to choose one Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the chosen Network Pharmacy. If you don't make a choice within 31 days of the date we notify you, we will choose a Network Pharmacy for you.

## Rebates and Other Payments

We may receive rebates for certain drugs included on the Prescription Drug List, including those drugs that you purchase prior to meeting any applicable deductible. As determined by us, we may pass a portion of these rebates on to you. When rebates are passed on to you, they may be taken into account in determining your Co-payment and/or Co-insurance.

We, and a number of our affiliated entities, conduct business with pharmaceutical manufacturers separate and apart from this *Outpatient Prescription Drug* section. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this *Outpatient Prescription Drug* section. We are not required to pass on to you, and do not pass on to you, such amounts.

## Coupons, Incentives and Other Communications

At various times, we may send mailings or provide other communications to you, your Physician, or your pharmacy that communicate a variety of messages, including information about Prescription and non-prescription Drug Products. These communications may include offers that enable you, as you determine, to purchase the described product at a discount. In some instances, non-UnitedHealthcare entities may support and/or provide content for these communications and offers. Only you and your Physician can determine whether a change in your Prescription and/or non-prescription Drug regimen is appropriate for your medical condition.

## Variable Co-payment Program

Certain Specialty Prescription Drug Products are eligible for coupons or offers from pharmaceutical manufacturers or affiliates that may reduce the cost for your Prescription Drug Product. We may help you determine whether your Specialty Prescription Drug Product is eligible for this reduction. If you redeem a coupon from a pharmaceutical manufacturer or affiliate, your Co-payment and/or Co-insurance may vary. Please contact [www.myuhc.com](http://www.myuhc.com) or the telephone number on your ID card for an available list of Specialty Prescription Drug Products. If you choose not to participate, you will pay the Co-payment or Co-insurance as described in the *Outpatient Prescription Drug Schedule of Benefits*.

The amount of the coupon will not count toward any applicable deductible or out-of-pocket limits.

## Special Programs

We may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens, and/or taking part in health management programs. You may access information on these programs by contacting us at [www.myuhc.com](http://www.myuhc.com) or the telephone number on your ID card.

## Maintenance Medication Program

If you require certain Maintenance Medications, we may direct you to the Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy to obtain those Maintenance Medications. If you choose not to obtain your Maintenance Medications from the Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy, you may opt-out of the Maintenance Medication Program by contacting us at [www.myuhc.com](http://www.myuhc.com) or the telephone number on your ID card. If you choose to opt out when directed to a Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy but do not inform us, you will be subject to the out-of-Network Benefit for that Prescription Drug Product after the allowed number of fills at Retail Network Pharmacy.

## Prescription Drug Products Prescribed by a Specialist

You may receive an enhanced or reduced Benefit, or no Benefit, based on whether the Prescription Drug Product was prescribed by a Specialist. You may access information on which Prescription Drug Products are subject to Benefit enhancement, reduction or no Benefit by contacting us at [www.myuhc.com](http://www.myuhc.com) or the telephone number on your ID card.

## Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at either a Network Pharmacy or an out-of-Network Pharmacy and are subject to Co-payments and/or Co-insurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is placed. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for applicable Co-payments and/or Co-insurance requirements.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Care Service or is prescribed to prevent conception.

## **Specialty Prescription Drug Products**

Benefits are provided for Specialty Prescription Drug Products.

If you require Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Specialty Prescription Drug Products.

If you are directed to a Designated Pharmacy and you have informed us of your decision not to obtain your Specialty Prescription Drug Product from a Designated Pharmacy, and you choose to obtain your Specialty Prescription Drug Product at a Non-Preferred Specialty Network Pharmacy, you will be subject to the Non-Preferred Specialty Network Co-payment and/or Co-insurance for that Specialty Prescription Drug Product.

Please see *Section 3: Defined Terms* for a full description of Specialty Prescription Drug Product and Designated Pharmacy.

The *Outpatient Prescription Drug Schedule of Benefits* will tell you how Specialty Prescription Drug Product supply limits apply.

## **Prescription Drugs from a Retail Network Pharmacy**

Benefits are provided for Prescription Drug Products dispensed by a retail Network Pharmacy.

The *Outpatient Prescription Drug Schedule of Benefits* will tell you how retail Network Pharmacy supply limits apply.

Depending upon your plan design, this *Outpatient Prescription Drug* section may offer limited Network Pharmacy providers. You can confirm that your pharmacy is a Network Pharmacy by calling the telephone number on your ID card or you can access a directory of Network Pharmacies online at [www.myuhc.com](http://www.myuhc.com).

## **Prescription Drugs from a Retail Out-of-Network Pharmacy**

Benefits are provided for Prescription Drug Products dispensed by a retail out-of-Network Pharmacy.

If the Prescription Drug Product is dispensed by a retail out-of-Network Pharmacy, you must pay for the Prescription Drug Product at the time it is dispensed. You can file a claim for reimbursement with us, as described in your *Certificate, Section 5: How to File a Claim*. We will not reimburse you for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge for that Prescription Drug Product. We will not reimburse you for any non-covered drug product.

In most cases, you will pay more if you obtain Prescription Drug Products from an out-of-Network Pharmacy.

The *Outpatient Prescription Drug Schedule of Benefits* will tell you how retail out-of-Network Pharmacy supply limits apply.

## **Prescription Drug Products from a Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy**

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy.

The *Outpatient Prescription Drug Schedule of Benefits* will tell you how mail order Network Pharmacy and Preferred 90 Day Retail Network Pharmacy supply limits apply.

Please contact us at [www.myuhc.com](http://www.myuhc.com) or the telephone number on your ID card to find out if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy.

## Section 2: Exclusions

Exclusions from coverage listed in the *Certificate* also apply to this section. In addition, the exclusions listed below apply.

When an exclusion applies to only certain Prescription Drug Products, you can contact us at [www.myuhc.com](http://www.myuhc.com) or the telephone number on your ID card for information on which Prescription Drug Products are excluded.

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
3. Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
4. Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
5. Experimental or Investigational or Unproven Services and medications; medications used for experimental treatments for specific diseases and/or dosage regimens determined by us to be experimental, investigational or unproven.
6. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
7. Prescription Drug Products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
8. Any product dispensed for the purpose of appetite suppression or weight loss.
9. A Pharmaceutical Product for which Benefits are provided in your *Certificate*. This includes certain forms of vaccines/immunizations. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
10. Durable Medical Equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your *Certificate*. Prescribed and non-prescribed outpatient supplies. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.
11. General vitamins, except the following, which require a Prescription Order or Refill:
  - Prenatal vitamins.
  - Vitamins with fluoride.
  - Single entity vitamins.
12. Certain unit dose packaging or repackagers of Prescription Drug Products.
13. Medications used for cosmetic purposes.
14. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Care Service.
15. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
16. Prescription Drug Products when prescribed to treat infertility. This exclusion does not apply to Prescription Drug Products prescribed to treat Iatrogenic Infertility and Preimplantation Genetic Testing (PGT) as described in the *Certificate*.



17. Certain Prescription Drug Products for tobacco cessation that exceed the minimum number of drugs required to be covered under the *Patient Protection and Affordable Care Act (PPACA)* in order to comply with essential health benefits requirements.
18. Prescription Drug Products not placed on Tier 1, Tier 2, Tier 3, or Tier 4 of the Prescription Drug List at the time the Prescription Order or Refill is dispensed. We have developed a process for reviewing Benefits for a Prescription Drug Product that is not on an available tier of the Prescription Drug List, but that has been prescribed as a Medically Necessary alternative. For information about this process, call the telephone number on your ID card.
19. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or made up of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that we have determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
20. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by our PDL Management Committee.
21. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
22. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of Sickness or Injury.
23. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
24. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
25. Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
26. Certain Prescription Drug Products that have not been prescribed by a Specialist.
27. A Prescription Drug Product that contains marijuana, including medical marijuana.
28. Certain Prescription Drug Products that exceed the minimum number of drugs required to be covered under the *Patient Protection and Affordable Care Act (PPACA)* essential health benefit requirements in the applicable *United States Pharmacopeia* category and class or applicable state benchmark plan category and class.
29. Dental products, including but not limited to prescription fluoride topicals.
30. A Prescription Drug Product with either:
  - An approved biosimilar.
  - A biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product.

For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on both of the following:

- It is highly similar to a reference product (a biological Prescription Drug Product).
- It has no clinically meaningful differences in terms of safety and effectiveness from the reference product.

Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

31. Diagnostic kits and products, including associated services..
32. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.
33. Certain Prescription Drug Products that are *FDA* approved as a package with a device or application, including smart package sensors and/or embedded drug sensors. This exclusion does not apply to a device or application that assists you with the administration of a Prescription Drug Product.

## Defined Terms

**Ancillary Charge** - a charge, in addition to the Co-payment and/or Co-insurance, that you must pay when a covered Prescription Drug Product is dispensed at your or the provider's request, when a Chemically Equivalent Prescription Drug Product is available.

For Prescription Drug Products from Network Pharmacies, the Ancillary Charge is the difference between:

- The Prescription Drug Charge for the Prescription Drug Product.
- The Prescription Drug Charge for the Chemically Equivalent Prescription Drug Product.

For Prescription Drug Products from out-of-Network Pharmacies, the Ancillary Charge is the difference between:

- The Out-of-Network Reimbursement Rate for the Prescription Drug Product.
- The Out-of-Network Reimbursement Rate for the Chemically Equivalent Prescription Drug Product.

**Brand-name** - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that we identify as a Brand-name product, based on available data resources. This includes data sources such as Medi-Span, that classify drugs as either brand or generic based on a number of factors. Not all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician will be classified as Brand-name by us.

**Chemically Equivalent** - when Prescription Drug Products contain the same active ingredient.

**Designated Pharmacy** - a pharmacy that has entered into an agreement with us or with an organization contracting on our behalf, to provide specific Prescription Drug Products. This includes Specialty Prescription Drug Products. Not all Network Pharmacies are Designated Pharmacies.

**Generic** - a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that we identify as a Generic product based on available data resources. This includes, data sources such as Medi-Span, that classify drugs as either brand or generic based on a number of factors. Not all products identified as a "generic" by the manufacturer, pharmacy or your Physician will be classified as a Generic by us.

**List of Preventive Medications** - a list that identifies certain Prescription Drug Products, which may include certain Specialty Prescription Drug Products, on the Prescription Drug List that are intended to reduce the likelihood of Sickness. You may find the List of Preventive Medications by contacting us at [www.myuhc.com](http://www.myuhc.com) or the telephone number on your ID card.

**List of Zero Cost Share Medications** - a list that identifies certain Prescription Drug Products on the Prescription Drug List that are available at zero cost share (no cost to you) when obtained from a retail Network Pharmacy. Certain Prescription Drug Products on the List of Zero Cost Share Medication may be available at a mail order Network Pharmacy. You may find the List of Zero Cost Share Medications by contacting us at [www.myuhc.com](http://www.myuhc.com) or the telephone number on your ID card.

The List of Zero Cost Share Medications includes certain Prescription Drug Products under these drug classes or categories:

- Insulins.
- Epinephrine.
- Glucagon.
- Naloxone.
- Albuterol inhalers and nebulized solutions.

**Maintenance Medication** - a Prescription Drug Product expected to be used for six months or more to treat or prevent a chronic condition. You may find out if a Prescription Drug Product is a Maintenance Medication by contacting us at [www.myuhc.com](http://www.myuhc.com) or the telephone number on your ID card.

**Maximum Allowable Amount** - the maximum amount that should be paid for covered Prescription Drug Products in a Therapeutic Class. This amount is subject to our review and change from time to time and varies by Therapeutic Class.

**Network Pharmacy** - a pharmacy that has:

- Entered into an agreement with us or an organization contracting on our behalf to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by us as a Network Pharmacy.

**New Prescription Drug Product** - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

- The date it is placed on a tier by our PDL Management Committee.
- December 31st of the following calendar year.

**Non-Preferred Specialty Network Pharmacy** - a specialty pharmacy that we identify as a non-preferred pharmacy within the Network.

**Out-of-Network Reimbursement Rate** - the amount we will pay to reimburse you for a Prescription Drug Product that is dispensed at an out-of-Network Pharmacy. The Out-of-Network Reimbursement Rate for a particular Prescription Drug Product dispensed at an out-of-Network Pharmacy includes a dispensing fee and any applicable sales tax.

**PPACA** - Patient Protection and Affordable Care Act of 2010.

**PPACA Zero Cost Share Preventive Care Medications** - the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Co-payment, Co-insurance, Annual Deductible, Annual Drug Deductible, or Specialty Prescription Drug Product Annual Deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

You may find out if a drug is a PPACA Zero Cost Share Preventive Care Medication as well as information on access to coverage of Medically Necessary alternatives by contacting us at [www.myuhc.com](http://www.myuhc.com) or the telephone number on your ID card.

**Preferred 90 Day Retail Network Pharmacy** - a retail pharmacy that we identify as a preferred pharmacy within the Network for Maintenance Medication.

**Preferred Specialty Network Pharmacy** - a specialty pharmacy that we identify as a preferred pharmacy within the Network.

**Prescription Drug Charge** - the rate we have agreed to pay our Network Pharmacies for a Prescription Drug Product dispensed at a Network Pharmacy. The rate includes any applicable dispensing fee and sales tax.

**Prescription Drug List** - a list that places into tiers medications or products that have been approved by the *U.S. Food and Drug Administration (FDA)*. This list is subject to our review and change from time to time. You may find out to which tier a particular Prescription Drug Product has been placed by contacting us at [www.myuhc.com](http://www.myuhc.com) or the telephone number on your ID card.

**Prescription Drug List (PDL) Management Committee** - the committee that we designate for placing Prescription Drug Products into specific tiers.

**Prescription Drug Product** - a medication or product that has been approved by the *U.S. Food and Drug Administration (FDA)* and that can, under federal or state law, be dispensed only according to a Prescription Order or Refill. A Prescription Drug Product includes a medication that is generally appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the Policy, this definition includes:

- Inhalers (with spacers).
- Insulin.
- Certain vaccines/immunizations administered at a Network Pharmacy.
- Certain injectable medications administered at a Network Pharmacy.
- The following diabetic supplies:
  - standard insulin syringes with needles;
  - blood-testing strips - glucose;
  - urine-testing strips - glucose;
  - ketone-testing strips and tablets;
  - lancets and lancet devices; and
  - glucose meters, including continuous glucose monitors.

**Prescription Order or Refill** - the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice allows issuing such a directive.

**Specialty Prescription Drug Product** - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. Specialty Prescription Drug Products include certain drugs for fertility preservation and Preimplantation Genetic Testing (PGT) for which Benefits are described in the *Certificate under Fertility Preservation for Iatrogenic Infertility and Preimplantation Genetic Testing (PGT) and Related Services* in *Section 1: Covered Health Care Services*. Specialty Prescription Drug Products may include drugs on the List of Preventive Medications. You may access a complete list of Specialty Prescription Drug Products by contacting us at [www.myuhc.com](http://www.myuhc.com) or the telephone number on your ID card.

**Therapeutically Equivalent** - when Prescription Drug Products have essentially the same efficacy and adverse effect profile.

**Usual and Customary Charge** - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. This fee includes any applicable dispensing fee and sales tax.

## Your Right to Request an Exclusion Exception

When a Prescription Drug Product is excluded from coverage, you or your representative may request an exception to gain access to the excluded Prescription Drug Product. To make a request, contact us in writing or call the toll-free number on your ID card. We will notify you of our determination within 72 hours.

Please note, if your request for an exception is approved by us, you may be responsible for paying the applicable Co-payment and/or Co-insurance based on the Prescription Drug Product tier placement, or at the highest tier as described in the Benefit Information table in the *Outpatient Prescription Drug Schedule of Benefits*, in addition to any applicable Ancillary Charge.

### Urgent Requests

If your request requires immediate action and a delay could significantly increase the risk to your health, or the ability to regain maximum function, call us as soon as possible. We will provide a written or electronic determination within 24 hours.

### External Review

If you are not satisfied with our determination of your exclusion exception request, you may be entitled to request an external review. You or your representative may request an external review by sending a written request to us to the address set out in the determination letter or by calling the toll-free number on your ID card. The *Independent Review Organization (IRO)* will notify you of our determination within 72 hours.

### Expedited External Review

If you are not satisfied with our determination of your exclusion exception request and it involves an urgent situation, you or your representative may request an expedited external review by calling the toll-free number on your ID card or by sending a written request to the address set out in the determination letter. The *IRO* will notify you of our determination within 24 hours.

## Section 11: Pediatric Dental Services

This section describes Benefits for Covered Dental Services for Covered Persons under the age of 19. Benefits under this section will end on the last day of the month the Covered Person reaches the age of 19.

### Benefits for Pediatric Dental Services

Benefits are provided for the Dental Services stated in this section when such services are:

- A. Necessary.
- B. Provided by or under the direction of a Dental Provider.
- C. Clinical situations that can be effectively treated by a less costly, dental appropriate alternative procedure will be given a Benefit based on the least costly procedure.
- D. Not excluded as described under *Pediatric Dental Exclusions* in this section.

#### Network Benefits:

Benefits for Allowed Dental Amounts are determined as a percentage of the negotiated contract fee between us and the provider rather than a percentage of the provider's billed charge. Our negotiated rate with the provider is ordinarily lower than the provider's billed charge.

A Network provider cannot charge you or us for any service or supply that is not Necessary. If you agree to receive a service or supply that is not Necessary the Network provider may charge you. However, these charges will not be considered Covered Dental Services and Benefits will not be payable.

#### Out-of-Network Benefits:

Benefits for Allowed Dental Amounts from out-of-Network providers are determined as a percentage of our contracted fee(s) for Covered Dental Services with a Network Dental Provider in the same geographic area. You must pay the amount by which the out-of-Network provider's billed charge exceeds the Allowed Dental Amount.

### Pediatric Dental Exclusions

Except as may be specifically provided in this section under *Benefits for Pediatric Dental Services*, Benefits are not provided under this section for the following:

- 1. Dental Services received from an out-of-Network Dental Provider.
- 2. Any Dental Service or Procedure not listed as a Covered Dental Service in this section under *Benefits for Pediatric Dental Services*.
- 3. Dental Services that are not Necessary.
- 4. Hospitalization or other facility charges.
- 5. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
- 6. Reconstructive surgery, regardless of whether or not the surgery is related to a dental disease, Injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.
- 7. Any Dental Procedure not directly related with dental disease.
- 8. Any Dental Procedure not performed in a dental setting.
- 9. Procedures that are considered to be Experimental or Investigational or Unproven Services. This includes pharmacological regimens not accepted by the *American Dental Association (ADA) Council on Dental Therapeutics*. The fact that an Experimental, or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

10. Drugs/medications, received with or without a prescription, unless they are dispensed and used in the dental office during the patient visit.
11. Setting of facial bony fractures and any treatment related with the dislocation of facial skeletal hard tissue.
12. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
13. Replacement of complete dentures, fixed and removable partial dentures or crowns and implants, implant crowns and prosthesis if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
14. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint.
15. Charges for not keeping a scheduled appointment without giving the dental office 24 hours notice.
16. Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled for coverage provided under this Policy.
17. Dental Services otherwise covered under the Policy, but provided after the date individual coverage under the Policy ends, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy ends.
18. Services rendered by a provider with the same legal residence as you or who is a member of your family, including spouse, brother, sister, parent or child.
19. Foreign Services are not covered unless required as an Emergency.
20. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
21. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
22. Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service.
23. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
24. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
25. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan.

## Claims for Pediatric Dental Services

When receiving Dental Services from an out-of-Network provider, you will be required to pay all billed charges directly to your Dental Provider. You may then seek reimbursement from us. Information about claim timelines and responsibilities in *Section 5: How to File a Claim* applies to Covered Dental Services provided under this section, except that when you submit your claim, you must provide us with all of the information shown below.

### Reimbursement for Dental Services

You are responsible for sending a request for reimbursement to our office, on a form provided by or satisfactory to us.

**Claim Forms.** It is not necessary to include a claim form with the proof of loss. However, the proof must include all of the following information:

- Covered Person's name and address.
- Covered Person's identification number.
- The name and address of the provider of the service(s).

- A diagnosis from the Dental Provider including a complete dental chart showing extractions, fillings or other dental services provided before the charge was incurred for the claim.
- Radiographs, lab or hospital reports.
- Casts, molds or study models.
- Itemized bill which includes the CPT or ADA codes or description of each charge.
- The date the dental disease began.
- A statement indicating that you are or you are not enrolled for coverage under any other health or dental insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

If you would like to use a claim form, call us at the telephone number stated on your ID card and a claim form will be sent to you. If you do not receive the claim form within 15 calendar days of your request, send in the proof of loss with the information stated above.

## Defined Terms for Pediatric Dental Services

The following definitions are in addition to those listed in *Section 9: Defined Terms*:

**Allowed Dental Amounts** - Allowed Dental Amounts for Covered Dental Services, incurred while the Policy is in effect, are determined as stated below:

- For Network Benefits, when Covered Dental Services are received from Network Dental Providers, Allowed Dental Amounts are our contracted fee(s) for Covered Dental Services with that provider.
- For Out-of-Network Benefits, when Covered Dental Services are received from Out-of-Network Dental Providers, Allowed Dental Amounts are our contracted fee(s) for Covered Dental Services with a Network Dental Provider in the same geographic area.

**Covered Dental Service** - a Dental Service or Dental Procedure for which Benefits are provided under this section.

**Dental Provider** - any dentist or dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to provide Dental Services, perform dental surgery or provide anesthetics for dental surgery.

**Dental Service or Dental Procedures** - dental care or treatment provided by a Dental Provider to a Covered Person while the Policy is in effect, provided such care or treatment is recognized by us as a generally accepted form of care or treatment according to prevailing standards of dental practice.

**Necessary** - Dental Services and supplies under this section which are determined through case-by-case assessments of care based on accepted dental practices to be appropriate and are all of the following:

- Necessary to meet the basic dental needs of the Covered Person.
- Provided in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Service.
- Consistent in type, frequency and duration of treatment with scientifically based guidelines of national clinical, research, or health care coverage organizations or governmental agencies that are accepted by us.
- Consistent with the diagnosis of the condition.
- Required for reasons other than the convenience of the Covered Person or his or her Dental Provider.
- Demonstrated through prevailing peer-reviewed dental literature to be either:
  - Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed; or
  - Safe with promising efficacy
    - ◆ For treating a life threatening dental disease or condition.
    - ◆ Provided in a clinically controlled research setting.
    - ◆ Using a specific research protocol that meets standards equivalent to those defined by the *National Institutes of Health*.



(For the purpose of this definition, the term life threatening is used to describe dental diseases or sicknesses or conditions, which are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a Dental Provider has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular dental disease does not mean that it is a Necessary Covered Dental Service as defined in this section. The definition of Necessary used in this section relates only to Benefits under this section and differs from the way in which a Dental Provider engaged in the practice of dentistry may define necessary.

## Section 12: Pediatric Vision Care Services

This section describes Benefits for Vision Care Services for Covered Persons under the age of 19. Benefits under this section will end on the last day of the month the Covered Person reaches the age of 19.

### Benefits for Pediatric Vision Care Services

#### Network Benefits:

Benefits for Vision Care Services are determined based on the negotiated contract fee between us and the Vision Care Provider. Our negotiated rate with the Vision Care Provider is ordinarily lower than the Vision Care Provider's billed charge.

#### Out-of-Network Benefits:

Benefits for Vision Care Services from out-of-Network providers are determined as a percentage of the provider's billed charge.

### Routine Vision Exam

A routine vision exam of the eyes and according to the standards of care in your area, including:

- A patient history that includes reasons for exam, patient medical/eye history, and current medications.
- Visual acuity with each eye and both eyes, far and near, with and without glasses or contact lenses (for example, 20/20 and 20/40).
- Cover test at 20 feet and 16 inches (checks how the eyes work together as a team).
- Ocular motility (how the eyes move) near point of convergence (how well eyes move together for near vision tasks, such as reading), and depth perception (3D vision).
- Pupil reaction to light and focusing.
- Exam of the eye lids, lashes, and outside of the eye.
- Retinoscopy (when needed) - helps to determine the starting point of the refraction which determines the lens power of the glasses.
- Phorometry/Binocular testing - far and near (how well eyes work as a team).
- Tests of accommodation - how well you see up close (for example, reading).
- Tonometry, when indicated - test pressure in eye (glaucoma check).
- Ophthalmoscopic exam of the inside of the eye.
- Visual field testing.
- Color vision testing.
- Diagnosis/prognosis.
- Specific recommendations.

Post exam procedures will be performed only when materials are required.

Or, in lieu of a complete exam, Retinoscopy (when applicable) - objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.

### Eyeglass Lenses

Lenses that are placed in eyeglass frames and worn on the face to correct visual acuity limitations.

You are eligible to choose only one of either eyeglasses (*Eyeglass Lenses* and/or *Eyeglass Frames*) or *Contact Lenses*. If you choose more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.

If you purchase *Eyeglass Lenses* and *Eyeglass Frames* at the same time from the same UnitedHealthcare Vision Network Vision Care Provider, only one Co-payment will apply to those *Eyeglass Lenses* and *Eyeglass Frames* together.

## **Eyeglass Frames**

A structure that contains eyeglass lenses, holding the lenses in front of the eyes and supported by the bridge of the nose.

You are eligible to choose only one of either eyeglasses (*Eyeglass Lenses* and/or *Eyeglass Frames*) or *Contact Lenses*. If you choose more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.

If you purchase *Eyeglass Lenses* and *Eyeglass Frames* at the same time from the same UnitedHealthcare Vision Network Vision Care Provider, only one Co-payment will apply to those *Eyeglass Lenses* and *Eyeglass Frames* together.

## **Contact Lenses**

Lenses worn on the surface of the eye to correct visual acuity limitations.

Benefits include the fitting/evaluation fees and contacts.

You are eligible to choose only one of either eyeglasses (*Eyeglass Lenses* and/or *Eyeglass Frames*) or *Contact Lenses*. If you choose more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.

## **Necessary Contact Lenses**

Benefits are available when a Vision Care Provider has determined a need for and has prescribed the contact lens. Such determination will be made by the Vision Care Provider and not by us.

Contact lenses are necessary if you have any of the following:

- Keratoconus.
- Anisometropia.
- Irregular corneal/astigmatism.
- Aphakia.
- Facial deformity.
- Corneal deformity.
- Pathological myopia.
- Aniseikonia.
- Aniridia.
- Post-traumatic disorders.

## **Low Vision**

Benefits are available to Covered Persons who have severe visual problems that cannot be corrected with regular lenses and only when a Vision Care Provider has determined a need for and has prescribed the service. Such determination will be made by the Vision Care Provider and not by us.

Benefits include:

- Low vision testing: Complete low vision analysis and diagnosis which includes:
  - A comprehensive exam of visual functions; and
  - The prescription of corrective eyewear or vision aids where indicated.
- Low vision therapy: Subsequent low vision therapy if prescribed.

## **Pediatric Vision Exclusions**

Except as may be specifically provided in this section under *Benefits for Pediatric Vision Care Services*, Benefits are not provided under this section for the following:

1. Medical or surgical treatment for eye disease which requires the services of a Physician and for which Benefits are available as stated in *Section 1: Covered Health Care Services*.
2. Non-prescription items (e.g. Plano lenses).

3. Replacement or repair of lenses and/or frames that have been lost or broken.
4. Optional Lens Extras not listed in *Benefits for Pediatric Vision Care Services*.
5. Missed appointment charges.
6. Applicable sales tax charged on Vision Care Services.

## Claims for Pediatric Vision Care Services

When obtaining Vision Care Services from an out-of-Network Vision Care Provider, you will be required to pay all billed charges directly to your Vision Care Provider. You may then seek reimbursement from us. Information about claim timelines and responsibilities in *Section 5: How to File a Claim* applies to Vision Care Services provided under this section, except that when you submit your claim, you must provide us with all of the information identified below.

## Reimbursement for Vision Care Services

To file a claim for reimbursement for Vision Care Services provided by a non-UnitedHealthcare Vision Network Vision Care Provider, or for Vision Care Services covered as reimbursements (whether or not provided by a UnitedHealthcare Vision Network Vision Care Provider or an out-of-Network Vision Care Provider), you must provide all of the following information on a claim form acceptable to us:

- Your itemized receipts.
- Covered Person's name.
- Covered Person's identification number from the ID card.
- Covered Person's date of birth.

Send the above information to us:

By mail:

Claims Department

P.O. Box 30978

Salt Lake City, UT 84130

By facsimile (fax):

248-733-6060

## Defined Terms for Pediatric Vision Care Services

The following definitions are in addition to those listed in *Section 9: Defined Terms*:

**Covered Contact Lens Selection** - a selection of available contact lenses that may be obtained from a UnitedHealthcare Vision Network Vision Care Provider on a covered-in-full basis, subject to payment of any applicable Co-payment.

**UnitedHealthcare Vision Network** - any optometrist, ophthalmologist, optician or other person designated by us who provides Vision Care Services for which Benefits are available under the Policy.

**Vision Care Provider** - any optometrist, ophthalmologist, optician or other person who may lawfully provide Vision Care Services.

**Vision Care Service** - any service or item listed in this section under *Benefits for Pediatric Vision Care Services*.

# UnitedHealthcare Choice Plus

## UnitedHealthcare Insurance Company

### Schedule of Benefits

CW-M6 , \$3,000

#### How Do You Access Benefits?

##### Selecting a Network Primary Care Physician

You must select a Network Primary Care Physician who is located in the geographic area of the permanent residence of the Subscriber. In general health care terminology, a Primary Care Physician may also be referred to as a *PCP*. A Network Primary Care Physician will be able to coordinate all Covered Health Care Services and promote continuity of care. If you are the custodial parent of an Enrolled Dependent child, you must select a Network Primary Care Physician who is located in the geographic area of the permanent residence of the Subscriber for that child.

You may designate a Network Physician who specializes in pediatrics (including pediatric subspecialties, based on the scope of that provider's license under applicable state law) as the Network Primary Care Physician for an Enrolled Dependent child. You do not need a referral from a Primary Care Physician and may seek care directly from a Specialist, including a Physician who specializes in obstetrics or gynecology.

You may change your Network Primary Care Physician by calling the telephone number shown on your ID card or by going to [www.myuhc.com](http://www.myuhc.com). Changes are permitted once per month. Changes submitted on or before the last day of the month will be effective on the first day of the following month.

You can choose to receive Designated Network Benefits, Network Benefits or Out-of-Network Benefits.

**Designated Network Benefits** apply to Covered Health Care Services that are provided by a provider or facility that has been identified as a Designated Provider. Designated Network Benefits are available only for specific Covered Health Care Services as shown in the *Schedule of Benefits* table below.

**Network Benefits** apply to Covered Health Care Services that are provided by a Network Physician or other Network provider.

**Out-of-Network Benefits** apply to Covered Health Care Services that are provided by an out-of-Network Physician or other out-of-Network provider, or Covered Health Care Services that are provided at an out-of-Network facility.

Emergency Health Care Services provided by an out-of-Network provider will be reimbursed as set forth under *Allowed Amounts* as described at the end of this *Schedule of Benefits*.

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

Ground and Air Ambulance transport provided by an out-of-Network provider will be reimbursed as set forth under *Allowed Amounts* as described at the end of this *Schedule of Benefits*.

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under a UnitedHealthcare Policy. As a result, they may bill you for the entire cost of the services you receive.

**Additional information about the network of providers and how your Benefits may be affected appears at the end of this *Schedule of Benefits*.**

If there is a conflict between this *Schedule of Benefits* and any summaries provided to you by the Group, this *Schedule of Benefits* will control.

## **Does Prior Authorization Apply?**

We require prior authorization for certain Covered Health Care Services. Network providers are responsible for obtaining prior authorization before they provide these services to you.

We recommend that you confirm with us that all Covered Health Care Services have been prior authorized as required. Before receiving these services from a Network provider, you may want to call us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they do not prior authorize as required. You can call us at the telephone number on your ID card.

**When you choose to receive certain Covered Health Care Services from out-of-Network providers, you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when an out-of-Network provider intends to admit you to a Network facility or to an out-of-Network facility or refers you to other Network or out-of-Network providers. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization. Services for which you are required to obtain prior authorization are shown in the *Schedule of Benefits* table within each Covered Health Care Service category.**

**To obtain prior authorization, call the telephone number on your ID card.** This call starts the utilization review process.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

**Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* table to find out how far in advance you must obtain prior authorization.**

For Covered Health Care Services that do not require you to obtain prior authorization, when you choose to receive services from out-of-Network providers, we urge you to confirm with us that the services you plan to receive are Covered Health Care Services. That's because in some instances, certain procedures may not be Medically Necessary or may not otherwise meet the definition of a Covered Health Care Service, and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Care Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those received, our final coverage determination will be changed to account for those differences, and we will only pay Benefits based on the services delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Care Service, you will be responsible for paying all charges and no Benefits will be paid.

## **Care Management**

When you seek prior authorization as required, we will work with you to put in place the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

## **Special Note Regarding Medicare**

If you are enrolled in Medicare on a primary basis (Medicare pays before we pay Benefits under the Policy), the prior authorization requirements do not apply to you. Since Medicare is the primary payer, we will pay as secondary payer as described in *Section 7: Coordination of Benefits*. You are not required to obtain authorization before receiving Covered Health Care Services.

## What Will You Pay for Covered Health Care Services?

Benefits for Covered Health Care Services are described in the tables below.

Annual Deductibles are calculated on a Policy year basis.

Out-of-Pocket Limits are calculated on a Policy year basis.

When Benefit limits apply, the limit stated refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.

Benefit limits are calculated on a Policy year basis unless otherwise specifically stated.

Payment Term And Description	Amounts
<b>Annual Deductible</b>	
<p>The amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits. Benefits for outpatient prescription drugs on the List of Preventive Medications are not subject to payment of the Annual Deductible.</p> <p>Coupons: We may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible.</p> <p>Amounts paid toward the Annual Deductible for Covered Health Care Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible.</p> <p>When a Covered Person was previously covered under a group policy that was replaced by the group Policy, any amount already applied to that annual deductible provision of the prior policy will apply to the Annual Deductible provision under the Policy.</p> <p>The amount that is applied to the Annual Deductible is calculated on the basis of the Allowed Amount or the Recognized Amount when applicable. The Annual Deductible does not include any amount that exceeds the Allowed Amount. Details about the way in which Allowed Amounts are determined appear at the end of the <i>Schedule of Benefits</i> table.</p> <p>The Annual Deductible does not include any applicable Per Occurrence Deductible.</p>	<p><b>Network</b></p> <p>\$3,000 per Covered Person, not to exceed \$6,000 for all Covered Persons in a family.</p> <p><b>Out-of-Network</b></p> <p>\$6,000 per Covered Person, not to exceed \$12,000 for all Covered Persons in a family.</p>
<b>Per Occurrence Deductible</b>	
<p>The amount stated as a set dollar amount that you must pay for certain Covered Health Care Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Care Services.</p> <p>You are responsible for paying the lesser of the following:</p>	<p>When a Per Occurrence Deductible applies, it is listed below under each Covered Health Care Service category.</p>



Payment Term And Description	Amounts
<ul style="list-style-type: none"> <li>• The applicable Per Occurrence Deductible.</li> <li>• The Allowed Amount or the Recognized Amount when applicable.</li> </ul>	
<b>Out-of-Pocket Limit</b>	
<p>The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Co-payments or Co-insurance. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year. The Out-of-Pocket Limit for Network Benefits includes the amount you pay for both Network and Out-of-Network Benefits for outpatient prescription drug products provided under the <i>Outpatient Prescription Drug</i> section of the <i>Certificate</i>.</p> <p>Details about the way in which Allowed Amounts are determined appear at the end of the <i>Schedule of Benefits</i> table.</p> <p>The Out-of-Pocket Limit does not include any of the following and, once the Out-of-Pocket Limit has been reached, you still will be required to pay the following:</p> <ul style="list-style-type: none"> <li>• Any charges for non-Covered Health Care Services.</li> <li>• The amount you are required to pay if you do not obtain prior authorization as required.</li> <li>• Charges that exceed Allowed Amounts, when applicable.</li> </ul> <p>Coupons: We may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Out-of-Pocket Limit.</p>	<p><b>Network</b></p> <p>\$7,000 per Covered Person, not to exceed \$14,000 for all Covered Persons in a family.</p> <p>The Out-of-Pocket Limit includes the Annual Deductible.</p> <p>The Out-of-Pocket Limit includes the Per Occurrence Deductible.</p> <p><b>Out-of-Network</b></p> <p>\$11,000 per Covered Person, not to exceed \$22,000 for all Covered Persons in a family.</p> <p>The Out-of-Pocket Limit includes the Annual Deductible.</p> <p>The Out-of-Pocket Limit includes the Per Occurrence Deductible.</p>
<b>Co-payment</b>	
<p>Co-payment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Care Services. When Co-payments apply, the amount is listed on the following pages next to the description for each Covered Health Care Service.</p> <p>Please note that for Covered Health Care Services, you are responsible for paying the lesser of:</p> <ul style="list-style-type: none"> <li>• The applicable Co-payment.</li> <li>• The Allowed Amount or the Recognized Amount when applicable.</li> </ul> <p>Details about the way in which Allowed Amounts are determined appear at the end of the <i>Schedule of Benefits</i> table.</p>	

Payment Term And Description	Amounts
<b>Co-insurance</b>	
<p>Co-insurance is the amount you pay (calculated as a percentage of the Allowed Amount or the Recognized Amount when applicable) each time you receive certain Covered Health Care Services.</p> <p>Details about the way in which Allowed Amounts are determined appear at the end of the <i>Schedule of Benefits</i> table.</p>	

***When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.***

**Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.**

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
1. Ambulance Services			
<p style="text-align: center;"><b>Prior Authorization Requirement</b></p> <p>In most cases, we will initiate and direct non-Emergency ambulance transportation.</p> <p>For Out-of-Network Benefits, if you are requesting non-Emergency Air Ambulance services (including any affiliated non-Emergency ground ambulance transport in conjunction with non-Emergency Air Ambulance transport), you must obtain authorization as soon as possible before transport. If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.</p>			
<b>Emergency Ambulance</b>  Allowed Amounts for ground and Air Ambulance transport provided by an out-of-Network provider will be determined as described below under <i>Allowed Amounts</i> in this <i>Schedule of Benefits</i> .	<b>Network</b>  <i>Ground Ambulance</i>  20%	Yes	Yes
	<i>Air Ambulance</i>  20%	Yes	Yes
	<b>Out-of-Network</b>  Same as Network	Same as Network	Same as Network

**When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.**

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
<b>Non-Emergency Ambulance</b>  Ground or Air Ambulance, as we determine appropriate.  Allowed Amounts for Air Ambulance transport provided by an out-of-Network provider will be determined as described below under <i>Allowed Amounts</i> in this <i>Schedule of Benefits</i> .	<b>Network</b>  <i>Ground Ambulance</i>  20%	Yes	Yes
	<i>Air Ambulance</i>  20%	Yes	Yes
	<b>Out-of-Network</b>  <i>Ground Ambulance</i>  50%	Yes	Yes
	<i>Air Ambulance</i>  Same as Network	Same as Network	Same as Network
<b>2. Cellular and Gene Therapy</b>			

***When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.***

**Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.**

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
For Network Benefits, Cellular or Gene Therapy services must be received from a Designated Provider.	<b>Network</b>  Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> .		
	<b>Out-of-Network</b>  Out-of-Network Benefits are not available.		
3. Clinical Trials			
<b>Prior Authorization Requirement</b>  For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Care Service, Benefit limits for clinical trials are the same as those stated under the specific Benefit category in this <i>Schedule of Benefits</i> . This does not apply to routine patient care costs associated with cancer clinical trials.	<b>Network</b>  Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> .		
	<b>Out-of-Network</b>  Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> .		

**When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.**

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
4. Congenital Heart Disease (CHD) Surgeries			
<p style="text-align: center;"><b>Prior Authorization Requirement</b></p> <p>For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of a CHD surgery arises. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.</p> <p><b>It is important that you notify us regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.</b></p>			
Benefits under this section include only the inpatient facility charges for the CHD surgery. Depending upon where the Covered Health Care Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> .	<p><b>Network</b></p> <p>Benefits will be the same as stated under <i>Hospital - Inpatient Stay</i> in this <i>Schedule of Benefits</i>.</p>		
	<p><b>Out-of-Network</b></p> <p>Benefits will be the same as stated under Hospital - Inpatient Stay in this Schedule of Benefits.</p>		
5. Dental Services - Accident Only			
	<p><b>Network</b></p> <p>20%</p>	Yes	Yes

**When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.**

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
	<b>Out-of-Network</b>  Same as Network	Same as Network	Same as Network
6. Diabetes Services			
<p style="text-align: center;"><b>Prior Authorization Requirement</b></p> <p>For Out-of-Network Benefits, you must obtain prior authorization before obtaining any DME for the management and treatment of diabetes that costs more than \$1,000 (either retail purchase cost or cumulative retail rental cost of a single item). If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.</p>			
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care	<b>Network</b>  Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management and training/diabetic eye exams/foot care will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> .		
	<b>Out-of-Network</b>  Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management and training/diabetic eye exams/foot care will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> .		

**When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.**

**Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.**

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
<b>Diabetes Self-Management Items</b>  Benefits for diabetes equipment that meets the definition of DME are not subject to the limit stated under <i>Durable Medical Equipment (DME), Orthotics and Supplies</i> .	<b>Network</b>  Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under <i>Durable Medical Equipment (DME), Orthotics and Supplies</i> and in the <i>Outpatient Prescription Drug</i> section.		
	<b>Out-of-Network</b>  Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under <i>Durable Medical Equipment (DME), Orthotics and Supplies</i> and in the <i>Outpatient Prescription Drug</i> section.		
<b>7. Durable Medical Equipment (DME), Orthotics and Supplies</b>			
<b>Prior Authorization Requirement</b>  For Out-of-Network Benefits, you must obtain prior authorization before obtaining any DME or orthotic that costs more than \$1,000 (either retail purchase cost or cumulative retail rental cost of a single item). If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
To receive Network Benefits, you must obtain the DME or orthotic from the vendor we identify or from the prescribing Network Physician.	<b>Network</b>  20%	Yes	Yes



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**Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.**

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
	<b>Out-of-Network</b>  50%	Yes	Yes
<b>8. Emergency Health Care Services - Outpatient</b>			
<p><b>Note:</b> If you are confined in an out-of-Network Hospital after you receive outpatient Emergency Health Care Services, you must notify us within one business day or on the same day of admission if reasonably possible. We may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the out-of-Network Hospital after the date we decide a transfer is medically appropriate, Network Benefits will not be provided. Out-of-Network Benefits may be available if the continued stay is determined to be a Covered Health Care Service.</p> <p>If you are admitted as an inpatient to a Hospital directly from the Emergency room, the Benefits provided as described under <i>Hospital - Inpatient Stay</i> will apply. You will not have to pay the Emergency Health Care Services Co-payment, Co-insurance and/or deductible.</p> <p>Allowed Amounts for Emergency Health Care Services provided by an out-of-Network provider will be determined as described below under <i>Allowed Amounts</i> in this <i>Schedule of Benefits</i>.</p>	<b>Network</b>  \$500 per visit .	Yes	Yes

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Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
	<b>Out-of-Network</b>  Same as Network	Same as Network	Same as Network
9. Enteral Nutrition			
	<b>Network</b>  20%	Yes	Yes
	<b>Out-of-Network</b>  50%	Yes	Yes
10. Fertility Preservation for Iatrogenic Infertility			
<b>Prior Authorization Requirement</b>  For Out-of-Network Benefits, you must obtain prior authorization as soon as possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
Limited to \$20,000 per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy. This Benefit limit will be the same as and combined with those stated under <i>Preimplantation Genetic Testing (PGT) and Related Services</i> . Benefits are further limited to one cycle of fertility preservation	<b>Network</b>  20%	Yes	Yes

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Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
for Iatrogenic Infertility per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy.			
	<b>Out-of-Network</b>  50%	Yes	Yes
<b>11. Gender Dysphoria</b>			

#### **Prior Authorization Requirement for Surgical Treatment**

For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of surgery arises. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.

In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for an Inpatient Stay.

**It is important that you notify us as soon as the possibility of surgery arises. Your notification allows the opportunity for us to provide you with additional information and services that may be available to you and are designed to achieve the best outcomes for you.**

#### **Prior Authorization Requirement for Non-Surgical Treatment**

Depending upon where the Covered Health Care Service is provided, any applicable prior authorization requirements will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.

	<b>Network</b>  Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service
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***When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.***

**Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.**

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
	category in this <i>Schedule of Benefits</i> and in the <i>Outpatient Prescription Drug</i> section of the <i>Certificate</i> .		
	<b>Out-of-Network</b>  Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> and in the <i>Outpatient Prescription Drug</i> section of the <i>Certificate</i> .		
12. Habilitative Services			
<p style="text-align: center;"><b>Prior Authorization Requirement</b></p> <p>For Out-of-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.</p> <p>In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).</p>			
Habilitative services received during an Inpatient Stay in an Inpatient Rehabilitative Facility are not subject to an annual limit.  Outpatient therapies are limited per year as follows: <ul style="list-style-type: none"><li>30 visits of post-cochlear implant aural therapy.</li></ul>	<b>Network</b>  <i>Inpatient</i>  Depending upon where the Covered Health Care		

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Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
	Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> .		
<p>The following outpatient therapies are not subject to an annual limit:</p> <ul style="list-style-type: none"> <li>Physical therapy.</li> <li>Occupational therapy.</li> <li>Speech therapy.</li> <li>Manipulative treatment.</li> <li>Cognitive therapy.</li> </ul>	<p><i>Outpatient</i></p> <p>\$30 per visit</p>	Yes	No
	<p><b><i>Out-of-Network</i></b></p> <p><i>Inpatient</i></p> <p>Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.</p>		
	<p><i>Outpatient</i></p> <p>50%</p>	Yes	Yes
<b>13. Hearing Aids</b>			
Limited to \$2,500 every year. Benefits are further limited to a single purchase per hearing impaired ear every three years. Repair and/or replacement of a	<p><b><i>Network</i></b></p> <p>20%</p>	Yes	Yes

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Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
hearing aid would apply to this limit in the same manner as a purchase.			
	<b>Out-of-Network</b>  50%	Yes	Yes
14. Home Health Care			
<p><b>Prior Authorization Requirement</b></p> <p>For Out-of-Network Benefits, you must obtain prior authorization five business days before receiving services or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.</p>			
Home Health Care visits are not subject to an annual limit. One home visit equals up to four hours of skilled care services.  Private Duty Nursing services are not subject to an annual limit. One visit equals up to eight hours of skilled care services.  This visit limit does not include any service which is billed only for the administration of intravenous infusion.  To receive Network Benefits for the administration of intravenous infusion, you must receive services from a provider we identify.	<b>Network</b>  20%	Yes	Yes

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Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
	<i>Out-of-Network</i>  50%	Yes	Yes
15. Hospice Care			
<p><b>Prior Authorization Requirement</b></p> <p>For Out-of-Network Benefits, you must obtain prior authorization five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.</p> <p>In addition, for Out-of-Network Benefits, you must contact us within 24 hours of admission for an Inpatient Stay in a hospice facility.</p>			
	<i>Network</i>  20%	Yes	Yes
	<i>Out-of-Network</i>  50%	Yes	Yes

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Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
16. Hospital - Inpatient Stay			
<p><b>Prior Authorization Requirement</b></p> <p>For Out-of-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.</p> <p>In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).</p>			
	<b>Network</b>  20%	Yes	Yes
	<b>Out-of-Network</b>  50%	Yes	Yes
17. Lab, X-Ray and Diagnostic - Outpatient			
<p><b>Prior Authorization Requirement</b></p> <p>For Out-of-Network Benefits for Genetic Testing, sleep studies, stress echocardiography and transthoracic echocardiogram, you must obtain prior authorization five business days before scheduled services are received. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.</p>			



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<b>Covered Health Care Service</b>	<b>What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.</b>	<b>Does the Amount You Pay Apply to the Out-of-Pocket Limit?</b>	<b>Does the Annual Deductible Apply?</b>
<b>Lab Testing - Outpatient</b> Limited to 18 Presumptive Drug Tests per year. Limited to 18 Definitive Drug Tests per year. For Designated Network Benefits, laboratory services must be received from a Designated Diagnostic Provider.	<b>Designated Network</b>  20%	Yes	Yes
Network Benefits include laboratory services received from a Network provider that is not a Designated Diagnostic Provider.	<b>Network</b>  50%	Yes	Yes
	<b>Out-of-Network</b>  50%	Yes	Yes
<b>X-Ray and Other Diagnostic Testing - Outpatient</b>	<b>Network</b>  20%	Yes	Yes
	<b>Out-of-Network</b>  50%	Yes	Yes

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Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
18. Major Diagnostic and Imaging - Outpatient			
<p style="text-align: center;"><b>Prior Authorization Requirement</b></p> <p>For Out-of-Network Benefits for CT, PET scans, MRI, MRA, and nuclear medicine, including nuclear cardiology, you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.</p>			
For Designated Network Benefits, services must be received from a Designated Diagnostic Provider.	<p><b>Designated Network</b></p> <p>20%</p>	Yes	Yes
Network Benefits include services received from a Network provider that is not a Designated Diagnostic Provider.	<p><b>Network</b></p> <p>50%</p>	Yes	Yes, after the Per Occurrence Deductible of \$500 per service is satisfied
	<p><b>Out-of-Network</b></p> <p>50%</p>	Yes	Yes , after the Per Occurrence

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Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
			\$500 per service is satisfied
<b>19. Mental Health Care and Substance-Related and Addictive Disorders Services</b>			

#### **Prior Authorization Requirement**

For Out-of-Network Benefits for a scheduled admission for Mental Health Care and Substance-Related and Addictive Disorders Services (including an admission for services at a Residential Treatment facility), you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions).

In addition, for Out-of-Network Benefits, you must obtain prior authorization before the following services are received: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; Intensive Behavioral Therapy, including *Applied Behavior Analysis (ABA)*.

If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.

	<b>Network</b>  <i>Inpatient</i>  20%	Yes	Yes
	<i>Outpatient</i>  None	Yes	No

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Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
	20% for Partial Hospitalization/ Intensive Outpatient Treatment	Yes	Yes
	<b><i>Out-of-Network</i></b>  <i>Inpatient</i>  50%	Yes	Yes
	<i>Outpatient</i>  50%	Yes	Yes
	50% for Partial Hospitalization/ Intensive Outpatient Treatment	Yes	Yes

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Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
20. Obesity - Weight Loss Surgery			
<p style="text-align: center;"><b>Prior Authorization Requirement</b></p> <p>For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of obesity - weight loss surgery arises. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.</p> <p>In addition, for Out-of-Network Benefits you must contact us 24 hours before admission for an Inpatient Stay.</p> <p><b>It is important that you notify us regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.</b></p>			
For Network Benefits, obesity - weight loss surgery must be received from a Designated Provider.	<p><b>Network</b></p> <p>Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.</p>		
	<p><b>Out-of-Network</b></p> <p>Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.</p>		
21. Ostomy Supplies			
Limited to \$2,500 per year.	<p><b>Network</b></p> <p>20%</p>	Yes	Yes

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Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
	<b>Out-of-Network</b>  50%	Yes	Yes
<b>22. Pharmaceutical Products - Outpatient</b>			
	<b>Network</b>  20%	Yes	Yes
	<b>Out-of-Network</b>  50%	Yes	Yes
<b>23. Physician Fees for Surgical and Medical Services</b>			
Covered Health Care Services provided by an out-of-Network Physician in a certain Network facilities will apply the same cost sharing (Co-payment, Co-insurance and applicable deductible) as if those services were provided by a Network provider; however, Allowed Amounts will be determined as described below under <i>Allowed Amounts</i> in this <i>Schedule of Benefits</i> .	<b>Network</b>  20%	Yes	Yes

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Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
	<b>Out-of-Network</b>  50%	Yes	Yes
<b>24. Physician's Office Services - Sickness and Injury</b>			
<p>Co-payment/Co-insurance and any deductible for the following services also apply when the Covered Health Care Service is performed in a Physician's office:</p> <ul style="list-style-type: none"> <li>• Lab, radiology/X-rays and other diagnostic services described under <i>Lab, X-Ray and Diagnostic - Outpatient</i>.</li> <li>• Major diagnostic and nuclear medicine described under <i>Major Diagnostic and Imaging - Outpatient</i>.</li> <li>• Outpatient Pharmaceutical Products described under <i>Pharmaceutical Products - Outpatient</i>.</li> <li>• Diagnostic and therapeutic scopic procedures described under <i>Scopic Procedures - Outpatient Diagnostic and Therapeutic</i>.</li> <li>• Outpatient surgery procedures described under <i>Surgery - Outpatient</i>.</li> <li>• Outpatient therapeutic procedures described under <i>Therapeutic Treatments - Outpatient</i>.</li> </ul>	<p><b>Network</b></p> <p><b>For Covered Persons under the age of 19:</b></p> <p>None per visit for a Primary Care Physician office visit or \$60 per visit for a Specialist office visit</p> <p>None per visit for a Primary Care Physician Telehealth/Tele-medicine visit</p> <p><b>For Covered Persons age 19 and older:</b></p> <p>\$30 per visit for a Primary Care Physician</p>	Yes	No

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Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
	office visit or \$60 per visit for a Specialist office visit		
	\$30 per visit per visit for a Primary Care Physician Telehealth/Tele-medicine visit	Yes	No
	<b>Out-of-Network</b>  50%	Yes	Yes
<b>25. Pregnancy - Maternity Services</b>			

#### **Prior Authorization Requirement**

For Out-of-Network Benefits, you must obtain prior authorization as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.

	<b>Network</b>  Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> except that an Annual Deductible will not apply for a newborn child whose length of stay
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**When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.**

**Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.**

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
	in the Hospital is the same as the mother's length of stay.		
	<b>Out-of-Network</b>  Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.		
26. Preimplantation Genetic Testing (PGT) and Related Services			
<b>Prior Authorization Requirement</b>  For Out-of-Network Benefits, you must obtain prior authorization as soon as possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
Benefit limits for related services will be the same as, and combined with, those stated under <i>Fertility Preservation for Iatrogenic Infertility</i> . This limit does not include <i>Preimplantation Genetic Testing (PGT)</i> for the specific genetic disorder.  This limit includes Benefits for ovarian stimulation medications provided under the <i>Outpatient Prescription Drug</i> section.	<b>Network</b>  20%	Yes	Yes

**When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.**

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
	<b>Out-of-Network</b>  50%	Yes	Yes
<b>27. Preventive Care Services</b>			
Physician office services	<b>Network</b>  None	Yes	No
	<b>Out-of-Network</b>  50%	Yes	Yes
Lab, X-ray or other preventive tests	<b>Network</b>  None	Yes	No
	<b>Out-of-Network</b>  50%	Yes	Yes

**When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.**

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
Breast pumps	<b>Network</b>  None	Yes	No
	<b>Out-of-Network</b>  50%	Yes	Yes
28. Prosthetic Devices			
<p><b>Prior Authorization Requirement</b></p> <p>For Out-of-Network Benefits, you must obtain prior authorization before obtaining prosthetic devices that exceed \$1,000 in cost per device. If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.</p>			
	<b>Network</b>  20%	Yes	Yes
	<b>Out-of-Network</b>  50%	Yes	Yes

***When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.***

**Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.**

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
29. Reconstructive Procedures			
<p style="text-align: center;"><b>Prior Authorization Requirement</b></p> <p>For Out-of-Network Benefits, you must obtain prior authorization five business days before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.</p> <p>In addition, for Out-of-Network Benefits you must contact us 24 hours before admission for scheduled inpatient admissions or as soon as is reasonably possible for non-scheduled inpatient admissions.</p>			
	<p><b>Network</b></p> <p>Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.</p>		
	<p><b>Out-of-Network</b></p> <p>Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.</p>		
30. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment			
The following outpatient therapies are not subject to an annual limit:  • Physical therapy.	<p><b>Network</b></p> <p>\$30 per visit</p>	Yes	No

**When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.**

**Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.**

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
<ul style="list-style-type: none"> <li>Occupational therapy.</li> <li>Speech therapy.</li> <li>Cardiac rehabilitation therapy.</li> <li>Manipulative treatment.</li> </ul> <p>Outpatient therapies are limited per year as follows:</p> <ul style="list-style-type: none"> <li>20 visits of pulmonary rehabilitation therapy.</li> <li>30 visits of post-cochlear implant aural therapy.</li> <li>20 visits of cognitive rehabilitation therapy.</li> </ul>			
	<b>Out-of-Network</b>  50%	Yes	Yes
<b>31. Scopic Procedures - Outpatient Diagnostic and Therapeutic</b>			
	<b>Network</b>  20%	Yes	Yes

**When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.**

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
	<b>Out-of-Network</b>  50%	Yes	Yes
<b>32. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services</b>			
<p style="text-align: center;"><b>Prior Authorization Requirement</b></p> <p>For Out-of-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.</p> <p>In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.</p>			
	<b>Network</b>  20%	Yes	Yes
	<b>Out-of-Network</b>  50%	Yes	Yes

**When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.**

**Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.**

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
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### 33. Surgery - Outpatient

#### Prior Authorization Requirement

For Out-of-Network Benefits for cardiac catheterization, pacemaker insertion, implantable cardioverter defibrillators, diagnostic catheterization and electrophysiology implant and sleep apnea surgery, you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.

	<b>Network</b> 20%	Yes	Yes
	<b>Out-of-Network</b> 50%	Yes	Yes

### 34. Temporomandibular Joint (TMJ) Services

#### Prior Authorization Requirement

For Out-of-Network Benefits you must obtain prior authorization five business days before temporomandibular joint services are performed during an Inpatient Stay in a Hospital. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.

In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for scheduled inpatient admissions.

***When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.***

**Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.**

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
	<b>Network</b> Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> .		
	<b>Out-of-Network</b> Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> .		
35. Therapeutic Treatments - Outpatient			
<b>Prior Authorization Requirement</b>  For Out-of-Network Benefits, you must obtain prior authorization for the following outpatient therapeutic services five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. Services that require prior authorization: dialysis, intensity modulated radiation therapy and MR-guided focused ultrasound. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
	<b>Network</b>  20%	Yes	Yes



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**Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.**

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
	<b>Out-of-Network</b>  50%	Yes	Yes
<b>36. Transplantation Services</b>			
For Network Benefits, transplantation services must be received from a Designated Provider. We do not require that cornea transplants be received from a Designated Provider in order for you to receive Network Benefits.	<b>Network</b> Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i> .		
	<b>Out-of-Network</b> Out-of-Network Benefits are not available.		
<b>37. Urgent Care Center Services</b>			
Co-payments/Co-insurance and any deductible for the following services apply when the Covered Health Care Service is performed at an Urgent Care Center: <ul style="list-style-type: none"> <li>Lab, radiology/X-rays and other diagnostic services described under <i>Lab, X-Ray and Diagnostic - Outpatient</i>.</li> <li>Major diagnostic and nuclear medicine described under <i>Major Diagnostic and Imaging - Outpatient</i>.</li> <li>Outpatient Pharmaceutical Products described under <i>Pharmaceutical Products - Outpatient</i>.</li> </ul>	<b>Network</b>  \$50 per visit	Yes	No

**When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.**

**Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.**

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
<ul style="list-style-type: none"> <li>Diagnostic and therapeutic scopic procedures described under <i>Scopic Procedures - Outpatient Diagnostic and Therapeutic</i>.</li> <li>Outpatient surgery procedures described under <i>Surgery - Outpatient</i>.</li> <li>Outpatient therapeutic procedures described under <i>Therapeutic Treatments - Outpatient</i>.</li> </ul>			
	<b>Out-of-Network</b>  50%	Yes	Yes
<b>38. Urinary Catheters</b>			
	<b>Network</b>  20%	Yes	Yes
	<b>Out-of-Network</b>  50%	Yes	Yes

***When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.***

**Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.**

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
<b>39. Virtual Care Services</b>			
	<b><i>Network</i></b> None	Yes	No
	<b><i>Out-of-Network</i></b> 50%	Yes	Yes
<b>40. Wigs</b>			
Benefits are available for the first wig following cancer treatment, not to exceed one per calendar year	<b><i>Network</i></b> 20%	Yes	Yes
	<b><i>Out-of-Network</i></b> 50%	Yes	Yes

***When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.***

**Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.**

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
<b>Additional Benefits Required By Iowa Law</b>			
<b>41. Dental Anesthesia and Hospital Charges</b>			
<p style="text-align: center;"><b>Prior Authorization Requirement</b></p> <p>Depending upon where the Covered Health Care Service is provided, any applicable authorization requirements will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.</p>			
	<p><b>Network</b></p> <p>Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.</p>		
	<p><b>Out-of-Network</b></p> <p>Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.</p>		
<b>42. Telehealth Services</b>			
	<p><b>Network</b></p> <p>Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.</p>		

**When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.**

**Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in the *Certificate*, Recognized Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.**

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
	<p><b><i>Out-of-Network</i></b></p> <p>Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this <i>Schedule of Benefits</i>.</p>		

## Allowed Amounts

Allowed Amounts are the amount we determine that we will pay for Benefits.

- For Designated Network Benefits and Network Benefits for Covered Health Care Services provided by a Network provider, except for your cost sharing obligations, you are not responsible for any difference between Allowed Amounts and the amount the provider bills.
- For Out-of-Network Benefits, except as described below, you are responsible for paying, directly to the out-of-Network provider, any difference between the amount the provider bills you and the amount we will pay for Allowed Amounts.
  - For Covered Health Care Services that are ***Ancillary Services received at certain Network facilities on a non-Emergency basis from out-of-Network Physicians***, you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your Co-payment, Co-insurance or deductible which is based on the Recognized Amount as defined in the *Certificate*.
  - For Covered Health Care Services that are ***non-Ancillary Services received at certain Network facilities on a non-Emergency basis from out-of-Network Physicians who have not satisfied the notice and consent criteria as described below***, you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your Co-payment, Co-insurance or deductible which is based on the Recognized Amount as defined in the *Certificate*.
  - For Covered Health Care Services that are ***Emergency Health Care Services provided by an out-of-Network provider***, you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your applicable Co-payment, Co-insurance or deductible which is based on the Recognized Amount as defined in the *Certificate*.
  - For Covered Health Care Services that are ***Air Ambulance services provided by an out-of-Network provider***, you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your applicable Co-payment, Co-insurance or deductible which is based on the rates that would apply if the service was provided by a Network provider.

Allowed Amounts are determined in accordance with our reimbursement policy guidelines or as required by law, as described in the *Certificate*.

## Designated Network Benefits and Network Benefits

Allowed Amounts are based on the following:

- When Covered Health Care Services are received from a Designated Network and Network provider, Allowed Amounts are our contracted fee(s) with that provider.
- When Covered Health Care Services are received from an out-of-Network provider as arranged by us, Allowed Amounts are an amount negotiated by us or an amount permitted by law. Please contact us if you are billed for amounts in excess of your applicable Co-insurance, Co-payment or any deductible. We will not pay excessive charges or amounts you are not legally obligated to pay.

## Out-of-Network Benefits

**When Covered Health Care Services are received from an out-of-Network provider as described below, Allowed Amounts are determined as follows:**

- **For non-Emergency Covered Health Care Services received at certain Network facilities from out-of-Network Physicians** when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the *Public Service Act* with respect to a visit as defined by the Secretary, the Allowed Amount is based on either:
  - The reimbursement rate as determined by applicable state law or by an applicable state *All Payer Model Agreement*.
  - The initial payment made by us or the amount subsequently agreed to by the out-of-Network provider and us.
  - The amount determined by *Independent Dispute Resolution (IDR)*.

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

**IMPORTANT NOTICE:** For Ancillary Services, and for non-Ancillary Services provided without notice and consent, you are not responsible, and an out-of-Network Physician may not bill you, for amounts in excess of your applicable Co-payment, Co-insurance or deductible which is based on the Recognized Amount as defined in the *Certificate*.

- **For Emergency Health Care Services provided by an out-of-Network provider**, the Allowed Amount is based on either:
  - The reimbursement rate as determined by applicable state law or by an applicable state *All Payer Model Agreement*.
  - The initial payment made by us or the amount subsequently agreed to by the out-of-Network provider and us.
  - The amount determined by *Independent Dispute Resolution (IDR)*.

**IMPORTANT NOTICE:** You are not responsible, and an out-of-Network provider may not bill you, for amounts in excess of your applicable Co-payment, Co-insurance or deductible which is based on the Recognized Amount as defined in the *Certificate*.

- **For Air Ambulance transportation provided by an out-of-Network provider**, the Allowed Amount is based on either:
  - The reimbursement rate as determined by applicable state law or by an applicable state *All Payer Model Agreement*.
  - The initial payment made by us or the amount subsequently agreed to by the out-of-Network provider and us.
  - The amount determined by *Independent Dispute Resolution (IDR)*.

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

**When Covered Health Care Services are received from an out-of-Network provider, except as described above, Allowed Amounts are determined based on either of the following:**

- Negotiated rates agreed to by the out-of-Network provider and either us or one of our vendors, affiliates or subcontractors.
- If rates have not been negotiated, the none of the following amounts:
  - Allowed Amounts are determined based on 100% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market, with the exception of the following:
    - ◆ 50% of *CMS* for the same or similar freestanding laboratory service.
    - ◆ 45% of *CMS* for the same or similar Durable Medical Equipment from a freestanding supplier, or *CMS* competitive bid rates.
    - ◆ 70% of *CMS* for the same or similar physical therapy service from a freestanding provider.
  - When a rate is not published by *CMS* for the service, we use an available gap methodology to determine a rate for the service as follows:
    - ◆ For services other than pharmaceutical products, we use a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale or the amount typically accepted by a provider for the same or similar service. The relative value scale may be based on the difficulty, time, work, risk, location, and resources of the service. If the relative value scale(s) currently in use become no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at [www.myuhc.com](http://www.myuhc.com) for information regarding the vendor that provides the applicable gap fill relative value scale information.
    - ◆ For pharmaceutical products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems*, *Thomson Reuters* (published in its Red Book), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.
    - ◆ When a rate for a laboratory service is not published by *CMS* for the service and gap methodology does not apply to the service, the rate is based on the average amount negotiated with similar Network providers for the same or similar service.
    - ◆ When a rate for all other services is not published by *CMS* for the service and a gap methodology does not apply to the service, the Allowed Amount is based on 20% of the provider's billed charge.

We update the *CMS* published rate data on a regular basis when updated data from *CMS* becomes available. These updates are typically put in place within 30 to 90 days after *CMS* updates its data.

**IMPORTANT NOTICE:** Out-of-Network providers may bill you for any difference between the provider's billed charges and the Allowed Amount described here. This includes non-Ancillary Services when notice and consent is satisfied as described under section 2799B-2(d) of the *Public Service Act*.

## Provider Network

We arrange for health care providers to take part in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to choose your provider.

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

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling the telephone number on your ID card. A directory of

providers is available by contacting us at [www.myuhc.com](http://www.myuhc.com) or the telephone number on your ID card to request a copy. If you receive a Covered Health Care Service from an out-of-Network provider and were informed incorrectly by us prior to receipt of the Covered Health Care Service that the provider was a Network provider, either through our database, our provider directory, or in our response to your request for such information (via telephone, electronic, web-based or internet-based means), you may be eligible for cost sharing (Co-payment, Co-insurance and applicable deductible) that would be no greater than if the service had been provided from a Network provider.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits. However, if you are currently receiving treatment for Covered Health Care Services from a provider whose network status changes from Network to out-of-Network during such treatment due to termination (non-renewal or expiration) of the provider's contract, you may be eligible to request continued care from your current provider under the same terms and conditions that would have applied prior to termination of the provider's contract for specified conditions and care, such as serious and complex conditions, institutional or inpatient care, nonelective surgery, pregnancy and terminal illness, and timeframes, such as the lesser of 90 days or the date on which you are no longer a continuing care patient, as defined and described in the *No Surprises Act of the Consolidated Appropriations Act (P.L. 116-260)*.

This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud. If you would like help to find out if you are eligible for continuity of care Benefits, please call the telephone number on your ID card.

If you are currently undergoing a course of treatment using an out-of-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help to find out if you are eligible for transition of care Benefits, please call the telephone number on your ID card.

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

## **Designated Providers**

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

In both cases, Network Benefits will only be paid if your Covered Health Care Services for that condition are provided by or arranged by the Designated Provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants or cancer treatment) that might warrant referral to a Designated Provider. If you do not notify us in advance, and if you receive services from an out-of-Network facility (regardless of whether it is a Designated Provider) or other out-of-Network provider, Network Benefits will not be paid. Out-of-Network Benefits may be available if the special needs services you receive are Covered Health Care Services for which Benefits are provided under the Policy.

## **Health Care Services from Out-of-Network Providers Paid as Network Benefits**

If specific Covered Health Care Services are not available from a Network provider, you may be eligible for Network Benefits when Covered Health Care Services are received from out-of-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through an out-of-Network provider.



## **Limitations on Selection of Providers**

If we determine that you are using health care services in a harmful or abusive manner, or with harmful frequency, your selection of Network providers may be limited. If this happens, we may require you to select a single Network Physician to provide and coordinate all future Covered Health Care Services.

If you don't make a selection within 31 days of the date we notify you, we will select a single Network Physician for you.

If you do not use the selected Network Physician, Covered Health Care Services will be paid as Out-of-Network Benefits.

# Outpatient Prescription Drug

## Schedule of Benefits

### When Are Benefits Available for Prescription Drug Products?

Benefits are available for Prescription Drug Products at either a Network Pharmacy or an out-of-Network Pharmacy and are subject to Co-payments and/or Co-insurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is placed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Care Service or is prescribed to prevent conception.

### Benefits for Oral Chemotherapeutic Agents

Oral chemotherapeutic agent Prescription Drug Products will be provided at a level no less favorable than chemotherapeutic agents are provided under *Pharmaceutical Products - Outpatient* in your *Certificate*, regardless of tier placement.

### What Happens When a Brand-name Drug Becomes Available as a Generic?

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change. Therefore your Co-payment and/or Co-insurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

### What Happens When a Biosimilar Product Becomes Available for a Reference Product?

If a biosimilar becomes available for a reference product (a biological Prescription Drug Product), the tier placement of the reference product may change. Therefore, your Co-payment and/or Co-insurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular reference product.

### How Do Supply Limits Apply?

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Co-payment and/or Co-insurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed. Supply limits are subject, from time to time, to our review and change. This may limit the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may find out whether a Prescription Drug Product has a supply limit for dispensing by contacting us at [www.myuhc.com](http://www.myuhc.com) or the telephone number on your ID card.

### Do Prior Authorization Requirements Apply?

Before certain Prescription Drug Products are dispensed to you, your Physician, your pharmacist or you are required to obtain prior authorization from us or our designee. The reason for obtaining prior authorization from us is to determine whether the Prescription Drug Product, in accordance with our approved guidelines, is each of the following:

- It meets the definition of a Covered Health Care Service.
- It is not an Experimental or Investigational or Unproven Service.

We may also require you to obtain prior authorization from us or our designee so we can determine whether the Prescription Drug Product, in accordance with our approved guidelines, was prescribed by a Specialist.

## **Network Pharmacy Prior Authorization**

When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for obtaining prior authorization from us.

## **Out-of-Network Pharmacy Prior Authorization**

When Prescription Drug Products are dispensed at an out-of-Network Pharmacy, you or your Physician are responsible for obtaining prior authorization from us as required.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you may pay more for that Prescription Order or Refill. The Prescription Drug Products requiring prior authorization are subject, from time to time, to our review and change. There may be certain Prescription Drug Products that require you to notify us directly rather than your Physician or pharmacist. You may find out whether a particular Prescription Drug Product requires notification/prior authorization by contacting us at [www.myuhc.com](http://www.myuhc.com) or the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. Our contracted pharmacy reimbursement rates (our Prescription Drug Charge) will not be available to you at an out-of-Network Pharmacy. You may seek reimbursement from us as described in the *Certificate of Coverage (Certificate)* in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge (for Prescription Drug Products from a Network Pharmacy) or the Out-of-Network Reimbursement Rate (for Prescription Drug Products from an out-of-Network Pharmacy), less the required Co-payment and/or Co-insurance, Ancillary Charge and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Care Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits related to such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements related to such programs by contacting us at [www.myuhc.com](http://www.myuhc.com) or the telephone number on your ID card.

## **Does Step Therapy Apply?**

Certain Prescription Drug Products for which Benefits are described under this Prescription Drug Rider section are subject to step therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product(s) first.

You may find out whether a Prescription Drug Product is subject to step therapy requirements by contacting us at [www.myuhc.com](http://www.myuhc.com) or the telephone number on your ID card.

## **What Do You Pay?**

You are responsible for paying the applicable Co-payment and/or Co-insurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Co-payment and/or Co-insurance for PPACA Zero Cost Share Preventive Care Medications. You are not responsible for paying a Co-payment and/or Co-insurance for Prescription Drug Products on the List of Zero Cost Share Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is Chemically Equivalent. An Ancillary Charge does not apply to any Out-of-Pocket Limit.

The amount you pay for any of the following under this Rider will not be included in calculating any Out-of-Pocket Limit stated in your *Certificate*:

- Ancillary Charges.
- Any amount you pay for Prescription Drug Products for Iatrogenic Infertility and Preimplantation Genetic Testing (PGT) that exceeds the Maximum Policy Benefit.

- Certain coupons or offers from pharmaceutical manufacturers or an affiliate.
- The difference between the Out-of-Network Reimbursement Rate and an out-of-Network Pharmacy's Usual and Customary Charge for a Prescription Drug Product.
- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product. Our contracted rates (our Prescription Drug Charge) will not be available to you.

## Payment Information

Payment Term And Description	Amounts
<b>Iatrogenic Infertility and Preimplantation Genetic Testing (PGT) Maximum Policy Benefit</b>	
The maximum amount we will pay for any combination of covered Prescription Drug Products for Iatrogenic Infertility and Preimplantation Genetic Testing (PGT) during the entire period of time you are enrolled for coverage under the Policy.	\$5,000 per Covered Person.
<b>Co-payment and Co-insurance</b>	
<p><b>Co-payment</b></p> <p>Co-payment for a Prescription Drug Product at a Network or out-of-Network Pharmacy is a specific dollar amount.</p> <p><b>Co-insurance</b></p> <p>Co-insurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge.</p> <p>Co-insurance for a Prescription Drug Product at an out-of-Network Pharmacy is a percentage of the Out-of-Network Reimbursement Rate.</p> <p><b>Co-payment and Co-insurance</b></p> <p>Your Co-payment and/or Co-insurance is determined by the Prescription Drug List (PDL) Management Committee's tier placement of a Prescription Drug Product.</p> <p>We may cover multiple Prescription Drug Products for a single Co-payment and/or Co-insurance if the combination of these multiple products provides a therapeutic treatment regimen that is supported by available clinical evidence. You may determine whether a therapeutic treatment regimen qualifies for a single Co-payment and/or Co-insurance by contacting us at <a href="http://www.myuhc.com">www.myuhc.com</a> or the telephone number on your ID card.</p> <p>Your Co-payment and/or Co-insurance may be reduced when you participate in certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits</p>	<p>For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lowest of the following:</p> <ul style="list-style-type: none"> <li>• The applicable Co-payment and/or Co-insurance.</li> <li>• The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product.</li> <li>• The Prescription Drug Charge for that Prescription Drug Product.</li> </ul> <p>For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following:</p> <ul style="list-style-type: none"> <li>• The applicable Co-payment and/or Co-insurance.</li> <li>• The Prescription Drug Charge for that Prescription Drug Product.</li> </ul> <p>See the Co-payments and/or Co-insurance stated in the Benefit Information table for amounts.</p> <p>You are not responsible for paying a Co-payment and/or Co-insurance for PPACA Zero Cost Share Preventive Care Medications.</p>

Payment Term And Description	Amounts
<p>associated with such programs. You may access information on these programs and any applicable prior authorization, participation or activation requirements associated with such programs by contacting us at <a href="http://www.myuhc.com">www.myuhc.com</a> or the telephone number on your ID card.</p> <p>Your Co-payment and/or Co-insurance for insulin will not exceed the amount allowed by applicable law.</p> <p><b>Special Programs:</b> We may have certain programs in which you may receive a reduced or increased Co-payment and/or Co-insurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs by contacting us at <a href="http://www.myuhc.com">www.myuhc.com</a> or the telephone number on your ID card.</p> <p><b>Co-payment/Co-insurance Waiver Program:</b> If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Co-payment and/or Co-insurance for one or more Prescription Orders or Refills.</p> <p><b>Variable Co-payment Program:</b></p> <p>Certain coupons from pharmaceutical manufacturers or an affiliate may reduce the costs of your Specialty Prescription Drug Products. Your Co-payment and/or Co-insurance may vary when you use a card for an available list of Specialty Prescription Drug Products and the applicable Co-payment and/or Co-insurance.</p> <p><b>Prescription Drug Products Prescribed by a Specialist:</b> You may receive a reduced or increased Co-payment and/or Co-insurance based on whether the Prescription Drug Product was prescribed by a Specialist. You may access information on which Prescription Drug Products are subject to a reduced or increased Co-payment and/or Co-insurance by contacting us at <a href="http://www.myuhc.com">www.myuhc.com</a> or the telephone number on your ID card.</p> <p><b>NOTE:</b> The tier status of a Prescription</p>	

Payment Term And Description	Amounts
<p>Drug Product can change from time to time. These changes generally happen quarterly but no more than six times per calendar year, based on the PDL Management Committee's tiering decisions. When that happens, you may pay more or less for a Prescription Drug Product, depending on its tier placement. Please contact us at <a href="http://www.myuhc.com">www.myuhc.com</a> or the telephone number on your ID card for the most up-to-date tier status.</p> <p><b>Coupons:</b> We may not permit you to use certain coupons or offers from pharmaceutical manufacturers or an affiliate to reduce your Co-payment and/or Co-insurance.</p>	

## Benefit Information

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.

Description and Supply Limits	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both
Specialty Prescription Drug Products	
<p>The following supply limits apply.</p> <ul style="list-style-type: none"> <li>As written by the provider, up to a consecutive 31-day supply of a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits, or as allowed under the Smart Fill Program.</li> </ul> <p>When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Co-payment and/or Co-insurance that applies will reflect the number of days dispensed or days the drug will be delivered.</p> <p>If a Specialty Prescription Drug Product is provided for less than or more than a 31-day supply, the Co-payment and/or Co-insurance that applies will reflect the number of days dispensed.</p> <p>We designate certain Network Pharmacies to be Preferred Specialty Network Pharmacies. We may periodically change the Preferred Specialty Network Pharmacy designation of a Network Pharmacy. These changes may occur without prior notice to you unless required by law. You may determine whether a Network Pharmacy is a Preferred Specialty Network Pharmacy by contacting us at <a href="http://www.myuhc.com">www.myuhc.com</a> or by the telephone number on your ID card.</p> <p>If you choose to obtain your Specialty Prescription Drug Product from a Non-Preferred Specialty Network Pharmacy, you will be required to pay 2 times the Preferred Specialty Network Pharmacy Co-payment and/or 2 times the Preferred</p>	<p>Your Co-payment and/or Co-insurance is determined by the PDL Management Committee's tier placement of the Specialty Prescription Drug Product. All Specialty Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2, Tier 3, or Tier 4. Please contact us at <a href="http://www.myuhc.com">www.myuhc.com</a> or the telephone number on your ID card to find out tier placement.</p> <p><b>Preferred Specialty Network Pharmacy</b></p> <p>For a Tier 1 Specialty Prescription Drug Product: \$10 per Prescription Order or Refill.</p> <p>For a Tier 1 Specialty Prescription Drug Product on the List of Preventive Medications: \$5 per Prescription Order or Refill.</p> <p>For a Tier 2 Specialty Prescription Drug Product: \$40 per Prescription Order or Refill.</p> <p>For a Tier 2 Specialty Prescription Drug Product on the List of Preventive Medications: \$5 per Prescription Order or Refill.</p> <p>For a Tier 3 Specialty Prescription Drug Product: \$125 per Prescription Order or Refill.</p> <p>For a Tier 3 Specialty Prescription Drug Product on the List of Preventive Medications: \$5 per Prescription Order or Refill.</p> <p>For a Tier 4 Specialty Prescription Drug Product: \$500 per Prescription Order or Refill.</p> <p>For a Tier 4 Specialty Prescription Drug Product on the List of Preventive Medications: \$5 per Prescription Order or Refill.</p>



The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.

Description and Supply Limits	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both
Specialty Network Pharmacy Co-insurance (up to 50% of the Prescription Drug Charge) based on the applicable Tier.	
<p>Supply limits apply to Specialty Prescription Drug Products obtained at a Preferred Specialty Network Pharmacy, a Non-Preferred Specialty Network Pharmacy, an out-of-Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.</p>	<p><b><i>Non-Preferred Specialty Network Pharmacy</i></b></p> <p>You will be required to pay 2 times the Preferred Specialty Network Pharmacy Co-payment and/or 2 times the Preferred Specialty Network Pharmacy Co-insurance (up to 50% of the Prescription Drug Charge) based on the applicable Tier.</p> <p><b><i>Out-of-Network Pharmacy</i></b></p> <p>For a Tier 1 Specialty Prescription Drug Product: \$10 per Prescription Order or Refill.</p> <p>For a Tier 1 Specialty Prescription Drug Product on the List of Preventive Medications: \$5 per Prescription Order or Refill.</p> <p>For a Tier 2 Specialty Prescription Drug Product: \$40 per Prescription Order or Refill.</p> <p>For a Tier 2 Specialty Prescription Drug Product on the List of Preventive Medications: \$5 per Prescription Order or Refill.</p> <p>For a Tier 3 Specialty Prescription Drug Product: \$125 per Prescription Order or Refill.</p> <p>For a Tier 3 Specialty Prescription Drug Product on the List of Preventive Medications: \$5 per Prescription Order or Refill.</p> <p>For a Tier 4 Specialty Prescription Drug Product: \$500 per Prescription Order or Refill.</p> <p>For a Tier 4 Specialty Prescription Drug Product on the List of Preventive Medications: \$5 per Prescription Order or Refill.</p>
<b>Prescription Drugs from a Retail Network Pharmacy</b>	
<p>The following supply limits apply:</p> <ul style="list-style-type: none"> <li>As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.</li> </ul> <p>A one-cycle supply of a contraceptive. You</p>	<p>Your Co-payment and/or Co-insurance is determined by the PDL Management Committee's tier placement of the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2, Tier 3, or Tier 4. Please contact us at <a href="http://www.myuhc.com">www.myuhc.com</a> or the telephone number on your ID card to find out tier status.</p> <p>For a Tier 1 Prescription Drug Product: \$10 per Prescription Order or Refill.</p>

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.

Description and Supply Limits	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both
<p>may obtain up to three cycles at one time if you pay a Co-payment and/or Co-insurance for each cycle supplied.</p> <p>When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Co-payment and/or Co-insurance that applies will reflect the number of days dispensed or days the drug will be delivered.</p>	<p>For a Tier 1 Prescription Drug Product on the List of Preventive Medications: \$5 per Prescription Order or Refill.</p> <p>For a Tier 2 Prescription Drug Product: \$40 per Prescription Order or Refill.</p> <p>For a Tier 2 Prescription Drug Product on the List of Preventive Medications: \$5 per Prescription Order or Refill.</p> <p>For a Tier 3 Prescription Drug Product: \$125 per Prescription Order or Refill.</p> <p>For a Tier 3 Prescription Drug Product on the List of Preventive Medications: \$5 per Prescription Order or Refill.</p> <p>For a Tier 4 Prescription Drug Product: \$300 per Prescription Order or Refill.</p> <p>For a Tier 4 Prescription Drug Product on the List of Preventive Medications: \$5 per Prescription Order or Refill.</p>
Prescription Drugs from a Retail Out-of-Network Pharmacy	
<p>The following supply limits apply:</p> <ul style="list-style-type: none"> <li>As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.</li> <li>A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Co-payment and/or Co-insurance for each cycle supplied.</li> </ul> <p>When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Co-payment and/or Co-insurance that applies will reflect the number of days dispensed or days the drug will be delivered.</p>	<p>Your Co-payment and/or Co-insurance is determined by the PDL Management Committee's tier placement of the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2, Tier 3, or Tier 4. Please contact us at <a href="http://www.myuhc.com">www.myuhc.com</a> or the telephone number on your ID card to find out tier status.</p> <p>For a Tier 1 Prescription Drug Product: \$10 per Prescription Order or Refill.</p> <p>For a Tier 1 Prescription Drug Product on the List of Preventive Medications: \$5 per Prescription Order or Refill.</p> <p>For a Tier 2 Prescription Drug Product: \$40 per Prescription Order or Refill.</p> <p>For a Tier 2 Prescription Drug Product on the List of Preventive Medications: \$5 per Prescription Order or Refill.</p> <p>For a Tier 3 Prescription Drug Product: \$125 per Prescription</p>

The amounts you are required to pay as shown below in the ***Outpatient Prescription Drug Schedule of Benefits*** are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.

Description and Supply Limits	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both
	<p>Order or Refill.</p> <p>For a Tier 3 Prescription Drug Product on the List of Preventive Medications: \$5 per Prescription Order or Refill.</p> <p>For a Tier 4 Prescription Drug Product: \$300 per Prescription Order or Refill.</p> <p>For a Tier 4 Prescription Drug Product on the List of Preventive Medications: \$5 per Prescription Order or Refill.</p>
<p><b>Prescription Drug Products from a Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy</b></p>	
<p>The following supply limits apply:</p> <ul style="list-style-type: none"> <li>As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. These supply limits do not apply to Specialty Prescription Drug Products. Specialty Prescription Drug Products from a mail order Network Pharmacy are subject to the supply limits stated above under the heading <i>Specialty Prescription Drug Products</i>.</li> </ul> <p>You may be required to fill the first Prescription Drug Product order and obtain 2 refills through a retail pharmacy before using a mail order Network Pharmacy.</p> <p>To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged a Co-payment and/or Co-insurance based on the day supply dispensed for any Prescription Orders or Refills sent to the mail order pharmacy or Preferred 90 Day Retail Network Pharmacy. Be sure your Physician writes your Prescription Order or Refill for a 90-day supply, not a 30-day supply with three refills.</p>	<p>Your Co-payment and/or Co-insurance is determined by the PDL Management Committee's tier placement the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on the Prescription Drug List are placed on Tier 1, Tier 2, Tier 3, or Tier 4. Please contact us at <a href="http://www.myuhc.com">www.myuhc.com</a> or the telephone number on your ID card to find out tier status.</p> <p>For up to a 31-day supply, at a mail order Network Pharmacy, you pay:</p> <p>For a Tier 1 Prescription Drug Product: \$10 per Prescription Order or Refill.</p> <p>For a Tier 1 Prescription Drug Product on the List of Preventive Medications: \$5 per Prescription Order or Refill.</p> <p>For a Tier 2 Prescription Drug Product: \$40 per Prescription Order or Refill.</p> <p>For a Tier 2 Prescription Drug Product on the List of Preventive Medications: \$5 per Prescription Order or Refill.</p> <p>For a Tier 3 Prescription Drug Product: \$125 per Prescription Order or Refill.</p> <p>For a Tier 3 Prescription Drug Product on the List of Preventive Medications: \$5 per Prescription Order or Refill.</p> <p>For a Tier 4 Prescription Drug Product: \$300 per Prescription Order or Refill.</p> <p>For a Tier 4 Prescription Drug Product on the List of Preventive Medications: \$5 per Prescription Order or Refill.</p> <p>For up to a 60-day supply at a mail order Network Pharmacy, you pay:</p>

The amounts you are required to pay as shown below in the ***Outpatient Prescription Drug Schedule of Benefits*** are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.

Description and Supply Limits	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both
	<p>For a Tier 1 Prescription Drug Product: \$20 per Prescription Order or Refill.</p> <p>For a Tier 1 Prescription Drug Product on the List of Preventive Medications: \$10 per Prescription Order or Refill.</p> <p>For a Tier 2 Prescription Drug Product: \$80 per Prescription Order or Refill.</p> <p>For a Tier 2 Prescription Drug Product on the List of Preventive Medications: \$10 per Prescription Order or Refill.</p> <p>For a Tier 3 Prescription Drug Product: \$250 per Prescription Order or Refill.</p> <p>For a Tier 3 Prescription Drug Product on the List of Preventive Medications: \$10 per Prescription Order or Refill.</p> <p>For a Tier 4 Prescription Drug Product: \$600 per Prescription Order or Refill.</p> <p>For a Tier 4 Prescription Drug Product on the List of Preventive Medications: \$10 per Prescription Order or Refill.</p> <p>For up to a 90-day supply at a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy, you pay:</p> <p>For a Tier 1 Prescription Drug Product: \$25 per Prescription Order or Refill.</p> <p>For a Tier 1 Prescription Drug Product on the List of Preventive Medications: \$12.50 per Prescription Order or Refill.</p> <p>For a Tier 2 Prescription Drug Product: \$100 per Prescription Order or Refill.</p> <p>For a Tier 2 Prescription Drug Product on the List of Preventive Medications: \$12.50 per Prescription Order or Refill.</p> <p>For a Tier 3 Prescription Drug Product: \$312.50 per Prescription Order or Refill.</p> <p>For a Tier 3 Prescription Drug Product on the List of Preventive Medications: \$12.50 per Prescription Order or Refill.</p> <p>For a Tier 4 Prescription Drug Product: \$750 per Prescription Order or Refill.</p> <p>For a Tier 4 Prescription Drug Product on the List of Preventive Medications: \$12.50 per Prescription Order or Refill.</p>

# Pediatric Dental Services

## Schedule of Benefits

This Schedule of Benefits describes Benefits for Covered Dental Services for Covered Persons under the age of 19. Benefits under this schedule will end on the last day of the month the Covered Person reaches the age of 19.

### Accessing Pediatric Dental Services

#### Network and Out-of-Network Benefits

**Network Benefits** - these Benefits apply when you choose to obtain Covered Dental Services from a Network Dental Provider. You generally are required to pay less to the provider than you would pay for services from an out-of-Network provider. Network Benefits are determined based on the contracted fee for each Covered Dental Service. In no event, will you be required to pay a Network Dental Provider an amount for a Covered Dental Service that is greater than the contracted fee.

In order for Covered Dental Services to be paid as Network Benefits, you must obtain all Covered Dental Services directly from or through a Network Dental Provider.

You must always check the participation status of a provider prior to seeking services. From time to time, the participation status of a provider may change. You can check the participation status by contacting us and/or the provider. We can provide help in referring you to Network Dental Provider.

We will make available to you a *Directory of Network Dental Providers*. You can also call us at the number stated on your identification (ID) card to determine which providers participate in the Network.

**Out-of-Network Benefits** - these Benefits apply when you decide to obtain Covered Dental Services from out-of-Network Dental Providers. You generally are required to pay more to the provider than for Network Benefits. Out-of-Network Benefits are determined based on our contracted fee(s) for Covered Dental Services with a Network Dental Provider in the same geographic area for each Covered Dental Service. The actual charge made by an out-of-Network Dental Provider for a Covered Dental Service may exceed the contracted fee(s). You may be required to pay an out-of-Network Dental Provider an amount for a Covered Dental Service in excess of the contracted fee(s). When you obtain Covered Dental Services from out-of-Network Dental Providers, you must file a claim with us to be reimbursed for Allowed Dental Amounts.

#### What Are Covered Dental Services?

You are eligible for Benefits for Covered Dental Services listed in this section if such Dental Services are Necessary and are provided by or under the direction of a Network Dental Provider.

Benefits are available only for Necessary Dental Services. The fact that a Dental Provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a dental disease, does not mean that the procedure or treatment is a Covered Dental Service under this section.

#### What Is a Pre-Treatment Estimate?

If the charge for a Dental Service is expected to exceed \$500 or if a dental exam reveals the need for fixed bridgework, you may notify us of such treatment before treatment begins and receive a pre-treatment estimate. If you desire a pre-treatment estimate, you or your Dental Provider should send a notice to us, via claim form, within 20 calendar days of the exam. If requested, the Dental Provider must provide us with dental x-rays, study models or other information necessary to evaluate the treatment plan for purposes of benefit determination.

We will determine if the proposed treatment is a Covered Dental Service and will estimate the amount of payment. The estimate of Benefits payable will be sent to the Dental Provider and will be subject to all terms, conditions and

provisions of the Policy. Clinical situations that can be effectively treated by a less costly, clinically acceptable alternative procedure will be given a benefit based on the less costly procedure.

A pre-treatment estimate of Benefits is not an agreement to pay for expenses. This procedure lets you know in advance approximately what portion of the expenses will be considered for payment.

### **Does Pre-Authorization Apply?**

Pre-authorization is required for orthodontic services. Speak to your Dental Provider about obtaining a pre-authorization before Dental Services are provided. If you do not obtain a pre-authorization, we have a right to deny your claim for failure to comply with this requirement.

## **Benefits**

### **Annual Deductible**

Benefits for pediatric Dental Services provided under this section are subject to the Annual Deductible stated in the Schedule of Benefits, unless otherwise specifically stated.

**Out-of-Pocket Limit** - any amount you pay in Co-insurance for pediatric Dental Services under this section applies to the Out-of-Pocket Limit stated in the medical *Schedule of Benefits*.

## **Benefits**

When Benefit limits apply, the limit stated refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.

Benefit limits are calculated on a Policy year basis unless otherwise specifically stated.

## Benefit Description

Amounts which you are required to pay as shown below in the *Dental Schedule of Benefits* are based on Allowed Dental Amounts.

**What Are the Procedure Codes, Benefit Description and Frequency Limitations?**

**Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.**

**Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.**

### ***Diagnostic Services - Network and Out-of-Network (Subject to payment of the Annual Deductible.)***

#### ***Evaluations (Checkup Exams)***

Limited to 2 times per 12 months.  
Covered as a separate Benefit only if no other service was done during the visit other than X-rays.

D0120 - Periodic oral evaluation.

D0140 - Limited oral evaluation - problem focused.

D9995 - Teledentistry - synchronous - real time encounter.

D9996 - Teledentistry - asynchronous - information stored and forwarded to dentist for subsequent review.

D0150 - Comprehensive oral evaluation - new or established patient.

D0180 - Comprehensive periodontal evaluation - new or established patient.

*The following service is not subject to a frequency limit.*

D0160 - Detailed and extensive oral evaluation - problem focused, by report.

None

50%

#### ***Intraoral Radiographs (X-ray)***

Limited to 2 series of films per 12 months.

D0210 - Intraoral complete series of radiographic images.

None

50%

**Amounts which you are required to pay as shown below in the *Dental Schedule of Benefits* are based on Allowed Dental Amounts.**

<b>What Are the Procedure Codes, Benefit Description and Frequency Limitations?</b>	<b>Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.</b>	<b>Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.</b>
D0709 - Intraoral - complete series of radiographic images - image capture only.		
<p><i>The following services are not subject to a frequency limit.</i></p> <p>D0220 - Intraoral - periapical first radiographic image.</p> <p>D0230 - Intraoral - periapical - each additional radiographic image.</p> <p>D0240 - Intraoral - occlusal radiographic image.</p> <p>D0706 - Intraoral - occlusal radiographic image - image capture only.</p> <p>D0707 - Intraoral - periapical radiographic image - image capture only.</p>	None	50%
<p><i>Any combination of the following services is limited to 2 series of films per 12 months.</i></p> <p>D0270 - Bitewings - single film.</p> <p>D0272 - Bitewings - two films.</p> <p>D0274 - Bitewings - four films.</p> <p>D0277 - Vertical bitewings.</p> <p>D0708 - Intraoral - bitewing radiographic image - image capture only.</p>	None	50%
<p>Limited to 1 time per 36 months.</p> <p>D0330 - Panoramic radiograph image.</p> <p>D0701 - Panoramic radiographic image - image capture only.</p>	None	50%



**Amounts which you are required to pay as shown below in the *Dental Schedule of Benefits* are based on Allowed Dental Amounts.**

<b>What Are the Procedure Codes, Benefit Description and Frequency Limitations?</b>	<b>Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.</b>	<b>Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.</b>
<p>D0702 - 2-D Cephalometric radiographic image - image capture only.</p> <p>D0704 - 3-D Photographic image - image capture only.</p>		
<p>The following services are limited to two images per calendar year.</p> <p>D0705 - Extra-oral posterior dental radiographic image - image capture only.</p>	None	50%
<p><i>The following services are not subject to a frequency limit.</i></p> <p>D0340 - 2-D Cephalometric radiographic image - acquisition, measurement and analysis.</p> <p>D0350 - 2-D Oral/facial photographic images obtained intra-orally or extra-orally.</p> <p>D0470 - Diagnostic casts.</p> <p>D0703 - 2-D Oral/facial photographic image obtained intra-orally or extra-orally - image capture only.</p>	None	50%
<b><i>Preventive Services - Network and Out-of-Network (Subject to payment of the Annual Deductible.)</i></b>		
<p><i>Dental Prophylaxis (Cleanings)</i></p> <p><i>The following services are limited to two times every 12 months.</i></p> <p>D1110 - Prophylaxis - adult.</p> <p>D1120 - Prophylaxis - child.</p>	None	50%

**Amounts which you are required to pay as shown below in the *Dental Schedule of Benefits* are based on Allowed Dental Amounts.**

<b>What Are the Procedure Codes, Benefit Description and Frequency Limitations?</b>	<b>Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.</b>	<b>Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.</b>
<p><i>Fluoride Treatments</i></p> <p><i>The following services are limited to two times every 12 months.</i></p> <p>D1206 - Topical application of fluoride varnish.</p> <p>D1208 - Topical application of fluoride - excluding varnish.</p>	None	50%
<p><i>Sealants (Protective Coating)</i></p> <p><i>The following services are limited to once per first or second permanent molar every 36 months.</i></p> <p>D1351 - Sealant - per tooth.</p> <p>D1352 - Preventive resin restorations in moderate to high caries risk patient - permanent tooth.</p>	None	50%
<p><i>Space Maintainers (Spacers)</i></p> <p><i>The following services are not subject to a frequency limit.</i></p> <p>D1510 - Space maintainer - fixed, unilateral - per quadrant.</p> <p>D1516 - Space maintainer - fixed - bilateral, maxillary.</p> <p>D1517 - Space maintainer - fixed - bilateral, mandibular.</p> <p>D1520 - Space maintainer - removable, unilateral - per quadrant.</p> <p>D1526 - Space maintainer - removable - bilateral, maxillary.</p> <p>D1527 - Space maintainer - removable - bilateral, mandibular.</p>	None	50%

**Amounts which you are required to pay as shown below in the *Dental Schedule of Benefits* are based on Allowed Dental Amounts.**

What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.	Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.
<p>D1551 - Re-cement or re-bond bilateral space maintainer - maxillary.</p> <p>D1552 - Re-cement or re-bond bilateral space maintainer - mandibular.</p> <p>D1553 - Re-cement or re-bond unilateral space maintainer - per quadrant.</p> <p>D1556 - Removal or fixed unilateral space maintainer - per quadrant.</p> <p>D1557 - Removal or fixed bilateral space maintainer - maxillary.</p> <p>D1558 - Removal of fixed bilateral space maintainer - mandibular.</p> <p>D1575 - Distal shoe space maintainer - fixed - unilateral - per quadrant.</p>		
<p><b><i>Minor Restorative Services - Network and Out-of-Network (Subject to payment of the Annual Deductible.)</i></b></p>		
<p><i>Amalgam Restorations (Silver Fillings)</i></p> <p><i>The following services are not subject to a frequency limit.</i></p> <p>D2140 - Amalgams - one surface, primary or permanent.</p> <p>D2150 - Amalgams - two surfaces, primary or permanent.</p> <p>D2160 - Amalgams - three surfaces, primary or permanent.</p> <p>D2161 - Amalgams - four or more surfaces, primary or permanent.</p>	20%	50%

**Amounts which you are required to pay as shown below in the *Dental Schedule of Benefits* are based on Allowed Dental Amounts.**

<b>What Are the Procedure Codes, Benefit Description and Frequency Limitations?</b>	<b>Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.</b>	<b>Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.</b>
<p><i>Composite Resin Restorations (Tooth Colored Fillings)</i></p> <p><i>The following services are not subject to a frequency limit.</i></p> <p>D2330 - Resin-based composite - one surface, anterior.</p> <p>D2331 - Resin-based composite - two surfaces, anterior.</p> <p>D2332 - Resin-based composite - three surfaces, anterior.</p> <p>D2335 - Resin-based composite - four or more surfaces or involving incisal angle, (anterior).</p>	20%	50%
<b><i>Crowns/Inlays/Onlays - Network and Out-of-Network (Subject to payment of the Annual Deductible.)</i></b>		
<p>The following services are subject to a limit of one time every 60 months.</p> <p>D2542 - Onlay - metallic - two surfaces.</p> <p>D2543 - Onlay - metallic - three surfaces.</p> <p>D2544 - Onlay - metallic - four or more surfaces.</p> <p>D2740 - Crown - porcelain/ceramic.</p> <p>D2750 - Crown - porcelain fused to high noble metal.</p> <p>D2751 - Crown - porcelain fused to predominately base metal.</p> <p>D2752 - Crown - porcelain fused to noble metal.</p> <p>D2753 - Crown -porcelain fused to titanium and titanium alloys.</p> <p>D2780 - Crown - 3/4 cast high noble metal.</p>	50%	50%

**Amounts which you are required to pay as shown below in the *Dental Schedule of Benefits* are based on Allowed Dental Amounts.**

What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.	Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.
<p>D2781 - Crown - 3/4 cast predominately base metal.</p> <p>D2783 - Crown - 3/4 porcelain/ceramic.</p> <p>D2790 - Crown - full cast high noble metal.</p> <p>D2791 - Crown - full cast predominately base metal.</p> <p>D2792 - Crown - full cast noble metal.</p> <p>D2794 - Crown - titanium and titanium alloys.</p> <p>D2930 - Prefabricated stainless steel crown - primary tooth.</p> <p>D2931 - Prefabricated stainless steel crown - permanent tooth.</p> <p><i>The following services are not subject to a frequency limit.</i></p> <p>D2510 - Inlay - metallic - one surface.</p> <p>D2520 - Inlay - metallic - two surfaces.</p> <p>D2530 - Inlay - metallic - three surfaces.</p> <p>D2910 - Re-cement or re-bond inlay.</p> <p>D2920 - Re-cement or re-bond crown.</p>		
<p>The following service is not subject to a frequency limit.</p> <p>D2940 - Protective restoration.</p>	50%	50%

**Amounts which you are required to pay as shown below in the *Dental Schedule of Benefits* are based on Allowed Dental Amounts.**

<b>What Are the Procedure Codes, Benefit Description and Frequency Limitations?</b>	<b>Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.</b>	<b>Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.</b>
<p>The following service is limited to one time per tooth every 60 months.</p> <p>D2929 - <i>Prefabricated porcelain/ceramic crown - primary tooth.</i></p> <p>D2950 - Core buildup, including any pins when required.</p>	50%	50%
<p>The following service is limited to one time per tooth every 60 months.</p> <p>D2951 - Pin retention - per tooth, in addition to restoration.</p>	50%	50%
<p>The following service is not subject to a frequency limit.</p> <p>D2954 - Prefabricated post and core in addition to crown.</p>	50%	50%
<p>The following service is not subject to a frequency limit.</p> <p>D2980 - Crown repair necessitated by restorative material failure.</p> <p>D2981 - Inlay repair.</p> <p>D2982 - Onlay repair.</p> <p>D2983 - Veneer repair.</p> <p>D2990 - Resin infiltration/smooth surface.</p>	50%	50%
<b><i>Endodontics - Network and Out-of-Network (Subject to payment of the Annual Deductible.)</i></b>		
<p><i>The following service is not subject to a frequency limit.</i></p> <p>D3220 - Therapeutic pulpotomy (excluding final restoration).</p>	20%	50%

**Amounts which you are required to pay as shown below in the *Dental Schedule of Benefits* are based on Allowed Dental Amounts.**

<b>What Are the Procedure Codes, Benefit Description and Frequency Limitations?</b>	<b>Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.</b>	<b>Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.</b>
<p><i>The following service is not subject to a frequency limit.</i></p> <p>D3222 - Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development.</p>	20%	50%
<p><i>The following service is not subject to a frequency limit.</i></p> <p>D3230 - Pulpal therapy (resorbable filling) - anterior primary tooth (excluding final restoration).</p> <p>D3240 - Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).</p>	20%	50%
<p><i>The following service is not subject to a frequency limit.</i></p> <p>D3310 - Endodontic therapy anterior tooth (excluding final restoration).</p> <p>D3320 - Endodontic therapy, premolar tooth (excluding final resoration).</p> <p>D3330 - Endodontic therapy, molar tooth (excluding final resoration).</p> <p>D3346 - Retreatment of previous root canal therapy - anterior.</p> <p>D3347 - Retreatment of previous root canal therapy - bicuspid.</p> <p>D3348 - Retreatment of previous root canal therapy - molar.</p>	20%	50%
<p><i>The following service is not subject to a frequency limit.</i></p> <p>D3351 - Apexification/recalcification - initial visit.</p>	20%	50%

**Amounts which you are required to pay as shown below in the *Dental Schedule of Benefits* are based on Allowed Dental Amounts.**

<b>What Are the Procedure Codes, Benefit Description and Frequency Limitations?</b>	<b>Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.</b>	<b>Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.</b>
<p>D3352 - Apexification/recalcification/pulpal regeneration - interim medication replacement.</p> <p>D3353 - Apexification/recalcification - final visit.</p>		
<i>The following service is not subject to a frequency limit.</i>	20%	50%
<p><i>The following service is not subject to a frequency limit.</i></p> <p>D3410 - Apicoectomy - anterior.</p> <p>D3421 - Apicoectomy - premolar (first root).</p> <p>D3425 - Apicoectomy - molar (first root).</p> <p>D3426 - Apicoectomy (each additional root).</p> <p>D3450 - Root amputation - per root.</p> <p>D3471 - Surgical repair of root resorption - anterior.</p> <p>D3472 - Surgical repair of root resorption - premolar.</p> <p>D3473 - Surgical repair of root resorption - molar.</p> <p>D3501 - Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior.</p> <p>D3502 - Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar.</p> <p>D3503 - Surgical exposure of root surface without apicoectomy or repair of root resorption - molar.</p>	20%	50%



**Amounts which you are required to pay as shown below in the *Dental Schedule of Benefits* are based on Allowed Dental Amounts.**

<b>What Are the Procedure Codes, Benefit Description and Frequency Limitations?</b>	<b>Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.</b>	<b>Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.</b>
<p><i>The following service is not subject to a frequency limit.</i></p> <p>D3911 - Intraorifice barrier.</p> <p>D3920 - Hemisection (including any root removal), not including root canal therapy.</p>	20%	50%
<b><i>Periodontics - Network and Out-of-Network (Subject to payment of the Annual Deductible.)</i></b>		
<p>The following services are limited to a frequency of one every 36 months.</p> <p>D4210 - Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant.</p> <p>D4211 - Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.</p>	20%	50%
<p><i>The following service is limited to one every 36 months.</i></p> <p>D4240 - Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant.</p> <p>D4241 - Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant.</p> <p>D4249 - Clinical crown lengthening - hard tissue.</p>	20%	50%
<p><i>The following service is limited to one every 36 months.</i></p> <p>D4260 - Osseous surgery (including flap entry and closure) - four or</p>	20%	50%

**Amounts which you are required to pay as shown below in the *Dental Schedule of Benefits* are based on Allowed Dental Amounts.**

<b>What Are the Procedure Codes, Benefit Description and Frequency Limitations?</b>	<b>Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.</b>	<b>Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.</b>
<p>more contiguous teeth or tooth bounded spaces per quadrant.</p> <p>D4261 - Osseous surgery (including flap entry and closure), one to three contiguous teeth or bounded teeth spaces per quadrant.</p> <p>D4263 - Bone replacement graft - retained natural tooth - first site in quadrant.</p>		
<p><i>The following service is not subject to a frequency limit.</i></p> <p>D4270 - Pedicle soft tissue graft procedure.</p>	20%	50%
<p><i>The following service is not subject to a frequency limit.</i></p> <p>D4273 - Autogenous connective tissue graft procedure, per first tooth implant or edentulous tooth position in graft.</p> <p>D4275 - Non-autogenous connective tissue graft first tooth implant.</p> <p>D4277 - Free soft tissue graft procedure - first tooth.</p> <p>D4278 - Free soft tissue graft procedure - each additional contiguous tooth.</p> <p>D4322 - Splint - intra-coronal; natural teeth or prosthetic crowns.</p> <p>D4323 - Splint - extra-coronal; natural teeth or prosthetic crowns.</p>	20%	50%
<p><i>The following services are limited to one time per quadrant every 24 months.</i></p> <p>D4341 - Periodontal scaling and</p>	20%	50%

**Amounts which you are required to pay as shown below in the *Dental Schedule of Benefits* are based on Allowed Dental Amounts.**

<b>What Are the Procedure Codes, Benefit Description and Frequency Limitations?</b>	<b>Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.</b>	<b>Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.</b>
<p>root planing - four or more teeth per quadrant.</p> <p>D4342 - Periodontal scaling and root planing - one to three teeth per quadrant.</p> <p>D4346 - Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation.</p>		
<p><i>The following service is limited to a frequency to one per lifetime.</i></p> <p>D4355 - Full mouth debridement to enable comprehensive oral evaluation and diagnosis on subsequent visit.</p>	20%	50%
<p><i>The following service is limited to four times every 12 months in combination with prophylaxis.</i></p> <p>D4910 - Periodontal maintenance.</p>	20%	50%

***Removable Dentures - Network and Out-of-Network (Subject to payment of the Annual Deductible.)***

<p><i>The following services are limited to a frequency of one every 60 months.</i></p> <p>D5110 - Complete denture - maxillary.</p> <p>D5120 - Complete denture - mandibular.</p> <p>D5130 - Immediate denture - maxillary.</p> <p>D5140 - Immediate denture - mandibular.</p> <p>D5211 - Maxillary partial denture - resin base (including retentive/clasping materials, rests,</p>		
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**Amounts which you are required to pay as shown below in the *Dental Schedule of Benefits* are based on Allowed Dental Amounts.**

<b>What Are the Procedure Codes, Benefit Description and Frequency Limitations?</b>	<b>Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.</b>	<b>Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.</b>
<p>and teeth).</p> <p>D5212 - Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth).</p> <p>D5213 - Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth).</p> <p>D5214 - Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth).</p> <p>D5221 - Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth).</p> <p>D5222 - Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth).</p> <p>D5223 - Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).</p> <p>D5224 - Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).</p> <p>D5227 - Immediate maxillary partial denture - flexible base (including any clasps, rests, and teeth).</p> <p>D5228 - Immediate mandibular partial denture - flexible base (including any clasps, rests, and teeth).</p>	<p>50%</p>	<p>50%</p>

**Amounts which you are required to pay as shown below in the *Dental Schedule of Benefits* are based on Allowed Dental Amounts.**

What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.	Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.
<p>D5282 - Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary.</p> <p>D5283 - Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular.</p> <p>D5284 - Removable unilateral partial denture - one piece flexible base (including retentive/clasping materials, rests, and teeth) - per quadrant.</p> <p>D5286 - Removable unilateral partial denture - one piece resin (including retentive/clasping materials, rests, and teeth) - per quadrant.</p>		
<p><i>The following services are not subject to a frequency limit.</i></p> <p>D5410 - Adjust complete denture - maxillary.</p> <p>D5411 - Adjust complete denture - mandibular.</p> <p>D5421 - Adjust partial denture - maxillary.</p> <p>D5422 - Adjust partial denture - mandibular.</p> <p>D5511 - Repair broken complete denture base - mandibular.</p> <p>D5512 - Repair broken complete denture base - maxillary.</p> <p>D5520 - Replace missing or broken teeth - complete denture (each tooth).</p>	50%	50%

**Amounts which you are required to pay as shown below in the *Dental Schedule of Benefits* are based on Allowed Dental Amounts.**

What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.	Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.
<p>D5610 - Repair resin denture base.</p> <p>D5611 - Repair resin partial denture base - mandibular.</p> <p>D5612 - Repair resin partial denture base - maxillary.</p> <p>D5620 - Repair cast framework.</p> <p>D5621 - Repair cast partial framework - mandibular.</p> <p>D5622 - Repair cast partial framework - maxillary.</p> <p>D5630 - Repair or replace broken retentive/clasping materials - per tooth.</p> <p>D5640 - Replace broken teeth - per tooth.</p> <p>D5650 - Add tooth to existing partial denture.</p> <p>D5660 - Add clasp to existing partial denture.</p>		
<p><i>The following services are limited to rebasing performed more than 6 months after the initial insertion with a frequency limitation of one time per 12 months.</i></p> <p>D5710 - Rebase complete maxillary denture.</p> <p>D5711 - Rebase complete mandibular denture.</p> <p>D5720 - Rebase maxillary partial denture.</p> <p>D5721 - Rebase mandibular partial denture.</p> <p>D5725 - Rebase hybrid prosthesis.</p>	50%	50%

**Amounts which you are required to pay as shown below in the *Dental Schedule of Benefits* are based on Allowed Dental Amounts.**

<b>What Are the Procedure Codes, Benefit Description and Frequency Limitations?</b>	<b>Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.</b>	<b>Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.</b>
D5730 - Reline complete maxillary denture (direct).  D5731 - Reline complete mandibular denture (direct).  D5740 - Reline maxillary partial denture (direct).  D5741 - Reline mandibular partial denture (direct).  D5750 - Reline complete maxillary denture (indirect).  D5751 - Reline complete mandibular denture (indirect).  D5760 - Reline maxillary partial denture (indirect).  D5761 - Reline mandibular partial denture (indirect).  D5876 - Add metal substructure to acrylic full denture (per arch).		
The following services are not subject to a frequency limit.  D5765 - Soft liner for complete or partial removable denture - indirect.  D5850 - Tissue conditioning (maxillary).  D5851 - Tissue conditioning (mandibular).	50%	50%
<b><i>Bridges (Fixed partial dentures(FPD)) - Network and Out-of-Network (Subject to payment of the Annual Deductible.)</i></b>		
<i>The following services are not subject to a frequency limit.</i>  D6210 - Pontic - cast high noble metal.	50%	50%

**Amounts which you are required to pay as shown below in the *Dental Schedule of Benefits* are based on Allowed Dental Amounts.**

<b>What Are the Procedure Codes, Benefit Description and Frequency Limitations?</b>	<b>Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.</b>	<b>Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.</b>
<p>D6211 - Pontic - cast predominately base metal.</p> <p>D6212 - Pontic - cast noble metal.</p> <p>D6214 - Pontic - titanium and titanium alloys.</p> <p>D6240 - Pontic - porcelain fused to high noble metal.</p> <p>D6241 - Pontic - porcelain fused to predominately base metal.</p> <p>D6242 - Pontic - porcelain fused to noble metal.</p> <p>D6243 - Pontic - porcelain fused to titanium and titanium alloys.</p> <p>D6245 - Pontic - porcelain/ceramic.</p>		
<p><i>The following services are not subject to a frequency limit.</i></p> <p>D6545 - Retainer - cast metal for resin bonded fixed prosthesis.</p> <p>D6548 - Retainer - porcelain/ceramic for resin bonded fixed prosthesis.</p>	50%	50%
<p><i>The following services are limited to one time every 60 months.</i></p> <p>D6740 - Retainer crown - porcelain/ceramic.</p> <p>D6750 - Retainer crown - porcelain fused to high noble metal.</p> <p>D6751 - Retainer crown - porcelain fused to predominately base metal.</p> <p>D6752 - Retainer crown - porcelain fused to noble metal.</p>	50%	50%



**Amounts which you are required to pay as shown below in the *Dental Schedule of Benefits* are based on Allowed Dental Amounts.**

What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.	Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.
<p>D6753 - Retainer crown - porcelain fused to titanium and titanium alloys.</p> <p>D6780 - Retainer crown - 3/4 cast high noble metal.</p> <p>D6781 - Retainer crown - 3/4 cast predominately base metal.</p> <p>D6782 - Retainer crown - 3/4 cast noble metal.</p> <p>D6783 - Retainer crown - 3/4 porcelain/ceramic.</p> <p>D6784 - Retainer crown - 3/4 titanium and titanium alloys.</p> <p>D6790 - Retainer crown - full cast high noble metal.</p> <p>D6791 - Retainer crown - full cast predominately base metal.</p> <p>D6792 - Retainer crown - full cast noble metal.</p>		
<p><i>The following service is not subject to a frequency limit.</i></p> <p>D6930 - Re-cement or re-bond FPD.</p>	50%	50%
<p><i>The following services are not subject to a frequency limit.</i></p> <p>D6980 - FPD repair necessitated by restorative material failure.</p>	50%	50%

Amounts which you are required to pay as shown below in the *Dental Schedule of Benefits* are based on Allowed Dental Amounts.

**What Are the Procedure Codes, Benefit Description and Frequency Limitations?**

**Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.**

**Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.**

***Oral Surgery - Network and Out-of-Network (Subject to payment of the Annual Deductible.)***

*The following service is not subject to a frequency limit.*

D7140 - Extraction, erupted tooth or exposed root.

20%

50%

*The following services are not subject to a frequency limit.*

D7210 - Surgical removal of erupted tooth requiring removal of bone, sectioning of tooth, and including elevation of mucoperiosteal flap, if indicated.

D7220 - Removal of impacted tooth - soft tissue.

D7230 - Removal of impacted tooth - partially bony.

D7240 - Removal of impacted tooth - completely bony.

D7241 - Removal of impacted tooth - completely bony with unusual surgical complications.

D7250 - Surgical removal or residual tooth roots.

D7251 - Coronectomy - intentional partial tooth removal.

20%

50%

*The following service is not subject to a frequency limit.*

D7270 - Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.

20%

50%

**Amounts which you are required to pay as shown below in the *Dental Schedule of Benefits* are based on Allowed Dental Amounts.**

<b>What Are the Procedure Codes, Benefit Description and Frequency Limitations?</b>	<b>Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.</b>	<b>Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.</b>
<p><i>The following service is not subject to a frequency limit.</i></p> <p>D7280 - Surgical access of an unerupted tooth.</p>	20%	50%
<p><i>The following services are not subject to a frequency limit.</i></p> <p>D7310 - Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.</p> <p>D7311 - Alveoloplasty in conjunction with extraction - one to three teeth or tooth space - per quadrant.</p> <p>D7320 - Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.</p> <p>D7321 - Alveoloplasty not in conjunction with extractions - one to three teeth or tooth space - per quadrant.</p>	20%	50%
<p><i>The following service is not subject to a frequency limit.</i></p> <p>D7471 - removal of lateral exostosis (maxilla or mandible).</p>	20%	50%
<p><i>The following services are not subject to a frequency limit.</i></p> <p>D7510 - Incision and drainage of abscess, intraoral soft tissue.</p> <p>D7910 - Suture of recent small wounds up to 5 cm.</p> <p>D7953 - Bone replacement graft for ridge preservation - per site.</p>	20%	50%

**Amounts which you are required to pay as shown below in the *Dental Schedule of Benefits* are based on Allowed Dental Amounts.**

<b>What Are the Procedure Codes, Benefit Description and Frequency Limitations?</b>	<b>Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.</b>	<b>Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.</b>
<p>D7961 - Buccal/labial frenectomy (frenulectomy).</p> <p>D7962 - Lingual frenectomy (frenulectomy).</p> <p>D7971 - Excision of pericoronal gingiva.</p>		
<b><i>Adjunctive Services - Network and Out-of-Network (Subject to payment of the Annual Deductible.)</i></b>		
<p><i>The following service is not subject to a frequency limit; however, it is covered as a separate Benefit only if no other services (other than the exam and radiographs) were done on the same tooth during the visit.</i></p> <p>D9110 - Palliative (Emergency) treatment of dental pain - minor procedure.</p>	20%	50%
<p><i>Covered only when clinically Necessary.</i></p> <p>D9222 - Deep sedation/general anesthesia - first 15 minutes.</p> <p>D9223 - Deep sedation/general anesthesia - each 15 minute increment.</p> <p>D9239 - Intravenous moderate (conscious) sedation/anesthesia - first 15 minutes.</p> <p>D9610 - Therapeutic parenteral drug single administration.</p>		
<p><i>Covered only when clinically Necessary.</i></p> <p>D9310 - Consultation (diagnostic service provided by a dentist or</p>	20%	50%

**Amounts which you are required to pay as shown below in the *Dental Schedule of Benefits* are based on Allowed Dental Amounts.**

<b>What Are the Procedure Codes, Benefit Description and Frequency Limitations?</b>	<b>Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.</b>	<b>Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.</b>
Physician other than the practitioner providing treatment).		
<p><i>The following is limited to one guard every 12 months.</i></p> <p>D9944 - Occlusal guard - hard appliance, full arch.</p> <p>D9945 - Occlusal guard - soft appliance, full arch.</p> <p>D9946 - Occlusal guard - hard appliance, partial arch.</p>	20%	50%
<b><i>Implant Procedures - Network and Out-of-Network (Subject to payment of the Annual Deductible.)</i></b>		
<p><i>The following services are limited to one time every 60 months.</i></p> <p>D6010 - Surgical placement of implant body: endosteal implant.</p> <p>D6012 - Surgical placement of interim implant body.</p> <p>D6040 - Surgical placement of eposteal implant.</p> <p>D6050 - Surgical placement: transosteal implant.</p> <p>D6055 - Connecting bar - implant supported or abutment supported.</p> <p>D6056 - Prefabricated abutment - includes modification and placement.</p> <p>D6057 - Custom fabricated abutment - includes placement.</p> <p>D6058 - Abutment supported porcelain/ceramic crown.</p> <p>D6059 - Abutment supported</p>		

**Amounts which you are required to pay as shown below in the *Dental Schedule of Benefits* are based on Allowed Dental Amounts.**

<b>What Are the Procedure Codes, Benefit Description and Frequency Limitations?</b>	<b>Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.</b>	<b>Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.</b>
<p>porcelain fused to metal crown (high noble metal).</p> <p>D6060 - Abutment supported porcelain fused to metal crown (predominately base metal).</p> <p>D6061 - Abutment supported porcelain fused to metal crown (noble metal).</p> <p>D6062 - Abutment supported cast metal crown (high noble metal).</p> <p>D6063 - Abutment supported cast metal crown (predominately base metal).</p> <p>D6064 - Abutment supported cast metal crown (noble metal).</p> <p>D6065 - Implant supported porcelain/ceramic crown.</p> <p>D6066 - Implant supported crown - porcelain fused to high noble alloys.</p> <p>D6067 - Implant supported crown - high noble alloys.</p> <p>D6068 - Abutment supported retainer for porcelain/ceramic FPD.</p> <p>D6069 - Abutment supported retainer for porcelain fused to metal FPD (high noble metal).</p> <p>D6070 - Abutment supported retainer for porcelain fused to metal FPD (predominately base metal).</p> <p>D6071 - Abutment supported retainer for porcelain fused to metal FPD (noble metal).</p> <p>D6072 - Abutment supported retainer for cast metal FPD (high noble metal).</p> <p>D6073 - Abutment supported retainer for cast metal FPD</p>		

**Amounts which you are required to pay as shown below in the *Dental Schedule of Benefits* are based on Allowed Dental Amounts.**

What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.	Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.
<p>(predominately base metal).</p> <p>D6074 - Abutment supported retainer for cast metal FPD (noble metal).</p> <p>D6075 - Implant supported retainer for ceramic FPD.</p> <p>D6076 - Implant supported retainer for FPD - porcelain fused to high noble alloys.</p> <p>D6077 - Implant supported retainer for metal FPD - high noble alloys.</p> <p>D6080 - Implant maintenance procedure.</p> <p>D6081 - Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure.</p> <p>D6082 - Implant supported crown - porcelain fused to predominantly base alloys.</p> <p>D6083 - Implant supported crown - porcelain fused to noble alloys.</p> <p>D6084 - Implant supported crown - porcelain fused to titanium and titanium alloys.</p> <p>D6086 - Implant supported crown - predominantly base alloys.</p> <p>D6087 - Implant supported crown - noble alloys.</p> <p>D6088 - Implant supported crown - titanium and titanium alloys.</p> <p>D6090 - Repair implant supported prosthesis, by report.</p> <p>D6091 - Replacement of replaceable part of semi-precision or precision</p>		

**Amounts which you are required to pay as shown below in the *Dental Schedule of Benefits* are based on Allowed Dental Amounts.**

<b>What Are the Procedure Codes, Benefit Description and Frequency Limitations?</b>	<b>Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.</b>	<b>Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.</b>
<p>attachment of implant/abutment supported prosthesis, per attachment.</p> <p>D6095 - Repair implant abutment, by report.</p> <p>D6096 - Remove broken implant retaining screw.</p> <p>D6097 - Abutment supported crown - porcelain fused to titanium and titanium alloys.</p> <p>D6098 - Implant supported retainer - porcelain fused to predominantly base alloys.</p> <p>D6099 - Implant supported retainer for FPD - porcelain fused to noble alloys.</p> <p>D6100 - Implant removal of implant body.</p> <p>D6101 - Debridement peri-implant defect.</p> <p>D6102 - Debridement and osseous contouring of a peri-implant defect.</p> <p>D6103 - Bone graft for repair peri-implant defect.</p> <p>D6104 - Bone graft at time of implant replacement.</p> <p>D6118 - Implant/abutment supported interim fixed denture for edentulous arch - mandibular.</p> <p>D6119 - Implant/abutment supported interim fixed denture for edentulous arch - maxillary.</p> <p>D6120 - Implant supported retainer - porcelain fused to titanium and titanium alloys.</p> <p>D6121 - Implant supported retainer for metal FPD - predominantly base</p>	<p>50%</p>	<p>50%</p>



Amounts which you are required to pay as shown below in the *Dental Schedule of Benefits* are based on Allowed Dental Amounts.

**What Are the Procedure Codes, Benefit Description and Frequency Limitations?**

**Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.**

**Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.**

alloys.

D6122 - Implant supported retainer for metal FPD - noble alloys.

D6123 - Implant supported retainer for metal FPD - titanium and titanium alloys.

D6190 - Radiographic/surgical implant index, by report.

D6191 - Semi-precision abutment - placement.

D6192 - Semi-precision attachment - placement.

D6195 - Abutment supported retainer - porcelain fused to titanium and titanium alloys.

***Medically Necessary Orthodontics***

***- Network and Out-of-Network (Subject to payment of the Annual Deductible.)***

Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, *Crouzon's Syndrome*, *Treacher-Collins Syndrome*, *Pierre-Robin Syndrome*, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies.

All orthodontic treatment must be prior authorized.

Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.

Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically Necessary.

*The following services are not subject to a frequency limitation as long as benefits have been prior authorized.*

D8010 - Limited orthodontic treatment of the primary dentition.

**Amounts which you are required to pay as shown below in the *Dental Schedule of Benefits* are based on Allowed Dental Amounts.**

What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.	Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.
<p>D8020 - Limited orthodontic treatment of the transitional dentition.</p> <p>D8030 - Limited orthodontic treatment of the adolescent dentition.</p> <p>D8070 - Comprehensive orthodontic treatment of the transitional dentition.</p> <p>D8080 - Comprehensive orthodontic treatment of the adolescent dentition.</p> <p>D8210 - Removable appliance therapy.</p> <p>D8220 - Fixed appliance therapy.</p> <p>D8660 - Pre-orthodontic treatment visit.</p> <p>D8670 - Periodic orthodontic treatment visit.</p> <p>D8680 - Orthodontic retention.</p> <p>D8695 - Removal of fixed orthodontic appliances for reasons other than completion of treatment.</p> <p>D8696 - Repair of orthodontic appliance - maxillary.</p> <p>D8697 - Repair of orthodontic appliance - mandibular.</p> <p>D8698 - Re-cement or re-bond fixed retainer - maxillary.</p> <p>D8699 - Re-cement or re-bond fixed retainer - mandibular.</p> <p>D8701 - Repair of fixed retainer,</p>	<p>50%</p>	<p>50%</p>

Amounts which you are required to pay as shown below in the *Dental Schedule of Benefits* are based on Allowed Dental Amounts.

What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.	Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.
includes reattachment - maxillary.  D8702 -Repair of fixed retainer, includes reattachment - mandibular.		

# Pediatric Vision Care Services

## Schedule of Benefits

This Schedule of Benefits describes Benefits for Vision Care Services for Covered Persons under the age of 19. Benefits under this schedule will end on the last day of the month the Covered Person reaches the age of 19.

### Benefits for Pediatric Vision Care Services

Benefits are available for pediatric Vision Care Services from a UnitedHealthcare Vision Network or out-of-Network Vision Care Provider. To find a UnitedHealthcare Vision Network Vision Care Provider, you may call the provider locator service at 1-800-839-3242. You may also access a listing of UnitedHealthcare Vision Network Vision Care Providers on the Internet at [www.myuhcvision.com](http://www.myuhcvision.com).

When you obtain Vision Care Services from an out-of-Network Vision Care Provider, you will be required to pay all billed charges at the time of service. You may then seek payment from us as described in the *Certificate* in *Section 5: How to File a Claim* and in this section under *Claims for Pediatric Vision Care Services*. Reimbursement will be limited to the amounts stated below.

When obtaining these Vision Care Services from a UnitedHealthcare Vision Network Vision Care Provider, you will be required to pay any Co-payments at the time of service.

#### Annual Deductible

Benefits for pediatric Vision Care Services provided under this schedule are subject to any Annual Deductible stated in the medical *Schedule of Benefits* unless otherwise specifically stated. Any amount you pay in Co-payments for Vision Care Services under this schedule does not apply to the Annual Deductible stated in the medical *Schedule of Benefits*.

**Out-of-Pocket Limit** - any amount you pay in Co-insurance for Vision Care Services under this section applies to the Out-of-Pocket Limit stated in the medical *Schedule of Benefits*. Any amount you pay in Co-payments for Vision Care Services under this section applies to the Out-of-Pocket Limit stated in the medical *Schedule of Benefits*.

#### Benefit Descriptions

When Benefit limits apply, the limit stated refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.

Benefit limits are calculated on a Policy year basis unless otherwise specifically stated.

#### Frequency of Service Limits

Benefits are provided for the Vision Care Services described below, subject to *Frequency of Service* limits and Co-payments and Co-insurance stated under each Vision Care Service in the *Schedule of Benefits* below.

<b>Vision Care Service</b>	<b>What Is the Frequency of Service?</b>	<b>Network Benefit - The Amount You Pay Based on the Contracted Rate</b>	<b>Out-of-Network Benefit - The Amount You Pay Based on Billed Charges</b>
<b><i>Routine Vision Exam or Refraction only in lieu of a complete exam</i></b>	Once every 12 months.	\$10 per exam.  Not subject to payment of the Annual Deductible.	50% of the billed charge.
<b><i>Eyeglass Lenses</i></b>	Once every 12 months.		
<ul style="list-style-type: none"> <li>Single Vision</li> </ul>		\$25 per pair of eyeglass lenses.  Not subject to payment of the Annual Deductible.	50% of the billed charge.
<ul style="list-style-type: none"> <li>Bifocal</li> </ul>		\$25 per pair of eyeglass lenses.  Not subject to payment of the Annual Deductible.	50% of the billed charge.
<ul style="list-style-type: none"> <li>Trifocal</li> </ul>		\$25 per pair of eyeglass lenses.  Not subject to payment of the Annual Deductible.	50% of the billed charge.
<ul style="list-style-type: none"> <li>Lenticular</li> </ul>		\$25 per pair of eyeglass lenses.  Not subject to payment of the Annual Deductible.	50% of the billed charge.
<b><i>Lens Extras</i></b>			

<ul style="list-style-type: none"> <li>Polycarbonate lenses</li> </ul>	Once every 12 months.	None  Not subject to payment of the Annual Deductible.	None
<ul style="list-style-type: none"> <li>Standard scratch-resistant coating</li> </ul>	Once every 12 months.	None  Not subject to payment of the Annual Deductible.	None

<b>Vision Care Service</b>	<b>What Is the Frequency of Service?</b>	<b>Network Benefit - The Amount You Pay Based on the Contracted Rate</b>	<b>Out-of-Network Benefit - The Amount You Pay Based on Billed Charges</b>
<b><i>Eyeglass Frames</i></b>	Once every 12 months.		
<ul style="list-style-type: none"> <li>• Eyeglass frames with a retail cost up to \$130.</li> </ul>		None  Not subject to payment of the Annual Deductible.	50% of the billed charge.
<ul style="list-style-type: none"> <li>• Eyeglass frames with a retail cost of \$130 - 160.</li> </ul>		\$15 per eyeglass frame.  Not subject to payment of the Annual Deductible.	50% of the billed charge.
<ul style="list-style-type: none"> <li>• Eyeglass frames with a retail cost of \$160 - 200.</li> </ul>		\$30 per eyeglass frame.  Not subject to payment of the Annual Deductible.	50% of the billed charge.
<ul style="list-style-type: none"> <li>• Eyeglass frames with a retail cost of \$200 - 250.</li> </ul>		\$50 per eyeglass frame.  Not subject to payment of the Annual Deductible.	50% of the billed charge.
<ul style="list-style-type: none"> <li>• Eyeglass frames with a retail cost greater than \$250.</li> </ul>		40%  Not subject to payment of the Annual Deductible.	50% of the billed charge.

Vision Care Service	What Is the Frequency of Service?	Network Benefit - The Amount You Pay Based on the Contracted Rate	Out-of-Network Benefit - The Amount You Pay Based on Billed Charges
<b>Contact Lenses and Fitting &amp; Evaluation</b>			
<ul style="list-style-type: none"> <li>Contact Lens Fitting &amp; Evaluation</li> </ul>	Once every 12 months.	None  Not subject to payment of the Annual Deductible.	None
<ul style="list-style-type: none"> <li>Covered Contact Lens Selection</li> </ul>	Limited to a 12 month supply.	\$25 per supply of contact lenses.  Not subject to payment of the Annual Deductible.	50% of the billed charge.
<b>Necessary Contact Lenses</b>	Limited to a 12 month supply.	\$25 per supply of contact lenses.  Not subject to payment of the Annual Deductible.	50% of the billed charge.
<b>Low Vision Care Services:</b> Note that Benefits for these services will be paid as reimbursements. When obtaining these Vision Care Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months.		
<ul style="list-style-type: none"> <li>Low vision testing</li> </ul>		None  Not subject to payment of the Annual Deductible.	25% of billed charges



<ul style="list-style-type: none"> <li>Low vision therapy</li> </ul>		25% of billed charges  Not subject to payment of the Annual Deductible.	25% of billed charges
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# **UnitedHealthcare Rewards Rider**

## **UnitedHealthcare Insurance Company**

This Rider to the Policy is issued to the Group and provides a description of the UnitedHealthcare Rewards wellness program.

Because this Rider is part of a legal document (the Group Policy), we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage* in *Section 9: Defined Terms*.

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company. When we use the words "you" and "your" we are referring to the Subscriber or their Enrolled Dependent Spouse.

## UnitedHealthcare Rewards Program

The Group has implemented a program that rewards you for completing certain wellness criteria, as described below. You may choose to complete any, or all, of the below wellness criteria to earn a reward.

If you are unable to meet a standard related to a health factor for a reward under the program, then you might qualify for an opportunity to earn the same reward by different means. You can call us at the telephone number listed on your ID card, and we will work with you (and, if necessary, with your Physician) to find another way for you to earn the same reward.

### You may receive one or more of the following:

- An activation credit that may be applied towards a device or deposited in your *Health Savings Account (HSA)* or distributed in other incentive types as applicable, administered by us.
- A device credit.
- Another type of incentive to help encourage you to participate in the program, administered as determined by us.

### Activity Targets

You may also receive a reward when you meet one or more of the activity targets listed below, based on the device you choose to track activity.

Activity Marker	Activity Target	Reward
Participation - Fitness	15 minutes of activity as designated by the program or 5,000 or more steps per day	You can earn rewards for one or multiple activity markers.
Active - Fitness	30 minutes or more of activity as designated by the program or 10,000 or more steps per day	
Other Health-Related Actions and/or Activities <ul style="list-style-type: none"><li>• Health education;</li><li>• Improving health; or</li><li>• Maintaining health</li></ul>	One or more actions and/or activities defined by us and aimed at the following:	

You may access your actions and/or activity tracking and rewards on the mobile application or [www.myuhc.com](http://www.myuhc.com).

If you have not achieved any of the above daily activity targets, you may be eligible to earn a reward for synchronizing or otherwise providing your daily actions and/or activities as defined by the program. This reward may not be provided if any of the activity targets are met.

The maximum reward will not exceed 30% of the cost of coverage for all programs combined, as applicable.

### Rewards

Rewards listed above, when earned, will be credited to a *Health Savings Account (HSA)* or distributed in other reward types as applicable, administered by us.

**Device**

A device, which includes an application, approved by us is used to track actions and/or activities towards earning a reward. If you choose to use a non-compatible device, you may be eligible to earn a reward; however, the reward may be limited.

UnitedHealthcare Insurance Company

A handwritten signature in cursive script that reads "Jessica Paik".

Jessica Paik, President

# Real Appeal Rider

## UnitedHealthcare Insurance Company

This Rider to the Policy provides Benefits for virtual obesity counseling services for eligible Covered Persons through Real Appeal. There are no deductibles, Co-payments or Co-insurance you must meet or pay for when receiving these services.

### Real Appeal

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

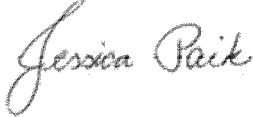
This intensive, multi-component behavioral intervention provides 52 weeks of support. This support includes one-on-one coaching with a live virtual coach and online group participation with supporting video content. The experience will be personalized for each individual through an introductory online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

These Covered Health Care Services will be individualized and may include the following:

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

If you would like information regarding these Covered Health Care Services, you may contact us through [www.realappeal.com](http://www.realappeal.com), <https://member.realappeal.com> or at the number shown on your ID card.

UnitedHealthcare Insurance Company



Jessica Paik, President

# Virtual Behavioral Health Therapy and Coaching Rider

## UnitedHealthcare Insurance Company

This Rider to the Policy provides Benefits for specialized virtual behavioral health care provided by AbleTo, Inc. for Covered Persons with certain co-occurring behavioral and medical conditions.

Because this Rider is part of a legal document (the Group Policy), we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage* in *Section 9: Defined Terms*.

AbleTo provides behavioral Covered Health Care Services through virtual therapy and coaching services that are individualized and tailored to your specific health needs. Virtual therapy is provided by licensed therapists. Coaching services are provided by coaches who are supervised by licensed professionals.

Except for Covered Persons with a high deductible health plan (HDHP) compatible with a Health Savings Account (HSA), there are no deductibles, Co-payments or Co-insurance you must meet or pay for when receiving these services.

Except for the initial consultation, Covered Persons with an HSA-compatible high deductible health plan (HDHP) must meet their Annual Deductible before they are able to receive Benefits for these services. There are no deductibles, Co-payments or Co-insurance for the initial consultation.

If you would like information regarding these services, you may call us at the telephone number on your ID card.



Jessica Paik, President

# Language Assistance Services

We<sup>1</sup> provide free language services to help you communicate with us. We offer interpreters, letters in other languages, and letters in other formats like large print. To get help, please call 1-866-633-2446, or the toll-free member phone number listed on your health plan ID card TTY/RTT711. We are available Monday through Friday, 8 a.m. to 8 p.m. ET.

ATENCION: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-866-633-2446.

請注意：如果您說中文 (**Chinese**)，我們免費為您提供語言協助服務。請致電：1-866-633-2446。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi 1-866-633-2446.

알림: 한국어(**Korean**)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-633-2446 번으로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Mangyaring tumawag sa 1-866-633-2446.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **Русский (Russian)**. Позвоните по номеру 1-866-633-2446.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال بـ 1-866-633-2446.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nan 1-866-633-2446.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le 1-866-633-2446.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod numer 1-866-633-2446.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para 1-866-633-2446.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero 1-866-633-2446.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie 1-866-633-2446 an.

注意事項：日本語 (**Japanese**) を話される場合、無料の言語支援サービスをご利用いただけます。1-866-633-2446 にお電話ください。

توجه: اگر زبان شما فارسی (**Farsi**) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. 1-866-633-2446 تماس بگیرید.

कृपा ध्यान दें: यदि आप **हिंदी (Hindi)** भाषी हैं तो आपके लिए भाषा सहायता सेवाएं निःशुल्क उपलब्ध हैं। कृपा पर काल करें 1-866-633-2446

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau 1-866-633-2446.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ(Khmer)**សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺបានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខ 1-866-633-2446។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti 1-866-633-2446.

Díí BAA'AKONÍNÍZIN: **Diné (Navajo)** bizaad bee yánilti'go, saad bee áka'anida'awo'ígíí, t'áá jiił'eh, bee na'ahóót'i'. T'áá shoodí kohjį' 1-866-633-2446 hodiilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac 1-866-633-2446.

ΠΡΟΣΟΧΗ : Αν μιλάτε **Ελληνικά (Greek)**, υπάρχει δωρεάν βοήθεια στη γλώσσα σας. Παρακαλείστε να καλέσετε 1-866-633-2446.

ધ્યાન આપો: જો તમે ગુજરાતી (**Gujarati**) બોલતા હો તો આપને ભાષાકીય મદદરૂપ સેવા વિના મૂલ્યે પ્રાપ્ય છે.

કૃપા કરી 1-866-633-2446 પર કોલ કરો.



## Notice of Non-Discrimination

We<sup>1</sup> do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

Civil Rights Coordinator  
UnitedHealthcare Civil Rights Grievance  
P.O. Box 30608  
Salt Lake City, UTAH 84130  
UHC\_Civil\_Rights@uhc.com

You must send the complaint within 60 days of the incident. We will send you a decision within 30 days. If you disagree with the decision, you have 15 days to appeal.

If you need help with your complaint, please call 1-866-633-2446 or the toll-free member phone number listed on your health plan ID card, TTY/RTT711. We are available Monday through Friday, 8 a.m. to 8 p.m ET

You can also file a complaint with the U.S. Dept. of Health and Human services.

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

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

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

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

<sup>1</sup> For purposes of the Language Assistance Services and this Non-Discrimination Notice ("Notice"), "we" refers to the entities listed in Footnote 2 of the Notice of Privacy Practices and Footnote 3 of the Financial Information Privacy Notice. Please note that not all entities listed are covered by this Notice.



# Important Notices

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

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

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

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

The amount you must pay for such Covered Health Care Services (including Co-payments, Co-insurance and any deductible) are the same as are required for any other Covered Health Care Service. Limitations on Benefits are the same as for any other Covered Health Care Service.

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

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

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

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

## Notice of Transition of Care

As required by the *No Surprises Act of the Consolidated Appropriations Act (P.L. 116-260)*, group health plans must provide Benefits for transition of care. If you are currently undergoing a course of treatment with a Physician or health care facility that is out-of-Network under this new plan, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help to find out if you are eligible for transition of care Benefits, please call the telephone number on your ID card.

## Claims and Appeal Notice

***This Notice is provided to you in order to describe our responsibilities under Federal law for making benefit determinations and your right to appeal adverse benefit determinations. To the extent that state law provides you with more generous timelines or opportunities for appeal, those rights also apply to you. Please refer to your benefit documents for information about your rights under state law.***

### Benefit Determinations

#### Post-service Claims

Post-service claims are those claims that are filed for payment of Benefits after medical care has been received. If your post-service claim is denied, you will receive a written notice from us within 30 days of receipt of the claim, as long as all needed information was provided with the claim. We will notify you within this 30 day period if additional information is needed to process the claim, and may request a one-time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, and the claim is denied, we will notify you of the denial within 30 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

If you have prescription drug Benefits and are asked to pay the full cost of a prescription when you fill it at a retail or mail-order pharmacy, and if you believe that it should have been paid under the Policy, you may submit a claim for reimbursement according to the applicable claim filing procedures. If you pay a Co-payment and believe that the amount of the Co-payment was incorrect, you also may submit a claim for reimbursement according to the applicable claim filing procedures. When you have filed a claim, your claim will be treated under the same procedures for post-service group health plan claims as described in this section.

#### Pre-service Requests for Benefits

Pre-service requests for Benefits are those requests that require notification or approval prior to receiving medical care. If you have a pre-service request for Benefits, and it was submitted properly with all needed information, we will send you written notice of the decision from us within 15 days of receipt of the request. If you filed a pre-service request for Benefits improperly, we will notify you of the improper filing and how to correct it within five days after the pre-service request for Benefits was received. If additional information is needed to process the pre-service request, we will notify you of the information needed within 15 days after it was received, and may request a one-time extension not longer than 15 days and pend your request until all information is received. Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, we will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your request for Benefits will be denied. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the appeal procedures.

If you have prescription drug Benefits and a retail or mail order pharmacy fails to fill a prescription that you have presented, you may file a pre-service health request for Benefits according to the applicable claim filing procedure. When you have filed a request for Benefits, your request will be treated under the same procedures for pre-service group health plan requests for Benefits as described in this section.

### Urgent Requests for Benefits that Require Immediate Attention

Urgent requests for Benefits are those that require notification or a benefit determination prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health, or the ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, could cause severe pain. In these situations, you will receive notice of the benefit determination in writing or electronically within 72 hours after we receive all necessary information, taking into account the seriousness of your condition.

If you filed an urgent request for Benefits improperly, we will notify you of the improper filing and how to correct it

within 24 hours after the urgent request was received. If additional information is needed to process the request, we will notify you of the information needed within 24 hours after the request was received. You then have 48 hours to provide the requested information.

You will be notified of a benefit determination no later than 48 hours after:

- Our receipt of the requested information.
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

## **Concurrent Care Claims**

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

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

## **Questions or Concerns about Benefit Determinations**

If you have a question or concern about a benefit determination, you may informally call us at the telephone number on your ID card before requesting a formal appeal. If the representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described above, you may appeal it as described below, without first informally contacting a representative. If you first informally contact us and later wish to request a formal appeal in writing, you should again contact us and request an appeal. If you request a formal appeal, a representative will provide you with the appropriate address.

If you are appealing an urgent claim denial, please refer to *Urgent Appeals that Require Immediate Action* below and contact us immediately.

## **How Do You Appeal a Claim Decision?**

If you disagree with a pre-service request for Benefits determination or post-service claim determination or a rescission of coverage determination after following the above steps, you can contact us in writing to formally request an appeal.

Your request for an appeal should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to us within 180 days after you receive the claim denial of pre-service request for benefits or a claim denial.

## Appeal Process

A qualified individual who was not involved in the decision being appealed will be chosen to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with expertise in the field, who was not involved in the prior determination. We may consult with, or ask medical experts to take part in the appeal process. You consent to this referral and the sharing of needed medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information related to your claim for Benefits. If any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge in advance of the due date of the response to the adverse benefit determination.

## Appeals Determinations

### Pre-service Requests for Benefits and Post-service Claim Appeals

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of pre-service requests for Benefits as shown above, the first level appeal will take place and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied request for Benefits. However, if your state requires two levels of appeal, the first level appeal will take place and you will be notified of the decision within 15 days.

If your state requires a second level appeal, it must be submitted to us within 60 days from receipt of the first level appeal decision. The second level appeal will take place and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.

- For appeals of post-service claims as shown above, the first level appeal will take place and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. However, if your state requires two levels of appeal, the first level appeal will take place and you will be notified of the decision within 30 days.

If your state requires a second level appeal, it must be submitted to us within 60 days from the receipt of the first level appeal decision. The second level appeal will take place and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures related to urgent requests for Benefits, see *Urgent Appeals that Require Immediate Action* below.

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure. The decision to obtain the proposed treatment or procedure regardless of our decision is between you and your Physician.

### Urgent Appeals that Require Immediate Action

Your appeal may require urgent action if a delay in treatment could increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.
- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If we need more information from your Physician to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information. The appeal process for urgent situations does not apply to prescheduled treatments, therapies, or surgeries.

# HEALTH PLAN NOTICES OF PRIVACY PRACTICES

## MEDICAL INFORMATION PRIVACY NOTICE

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.**

*Effective January 1, 2023:*

We<sup>2</sup> are required by law to protect the privacy of your health information. We are also required to send you this notice, which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice. We are required by law to abide by the terms of this notice.

The terms "information" or "health information" in this notice include any information we maintain that reasonably can be used to identify you and that relates to your physical or mental health care condition, the provision of health care to you, or the payment for such health care. We will comply with the requirements of applicable privacy laws related to notifying you in the event of a breach of your health information.

We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, we will provide to you, in our next annual distribution, either a revised notice or information about the material change and how to obtain a revised notice. We will provide you with this information either by direct mail or electronically, in accordance with applicable law. In all cases, if we maintain a website for your particular health plan, we will post the revised notice on your health plan website, such as [www.myuhc.com](http://www.myuhc.com). We have the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

UnitedHealth Group collects and maintains oral, written and electronic information to administer our business and to provide products, services and information of importance to our enrollees. We maintain physical, electronic and procedural security safeguards in the handling and maintenance of our enrollee's information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction or misuse.

### **How We Collect, Use, and Disclose Information**

**We** collect, use, and disclose your health information to provide that information:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice.
- To the *Secretary of the Department of Health and Human Services*, if necessary, to make sure your privacy is protected.

**We have the right to** collect, use, and disclose health information for your treatment, to pay for your health care and to operate our business. For example, we may use or disclose your health information:

- **For Payment** of premiums due us, to determine your coverage, and to process claims for health care services you receive, including for subrogation (when permitted by applicable law) or coordination of other benefits you may have. For example, we may tell a doctor whether you are eligible for coverage and what percentage of the bill may be covered.
- **For Treatment.** We may collect, use, and disclose health information to aid in your treatment or the coordination of your care. For example, we may collect information from, or disclose information to your physicians or hospitals to help them provide medical care to you.
- **For Health Care Operations.** We may collect, use, and disclose health information needed to operate and manage our business activities related to providing and managing your health care coverage. For example, we might talk to your physician to suggest a disease management or wellness program that could help improve your health or we may analyze data to determine how we can improve our services. We may also de-identify health information in accordance with applicable laws. After that information is de-identified, the information is no longer subject to this notice and we may use the information for any lawful purpose.

- **To Provide You Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law.
- **For Plan Sponsors.** If your coverage is through an employer sponsored group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration purposes if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with federal law.
- **For Underwriting Purposes.** We may collect, use, and disclose your health information for underwriting purposes; however, we will not use or disclose your genetic information for such purposes.
- **For Reminders.** We may use or disclose health information to send you reminders about your benefits or care, such as appointment reminders with providers who provide medical care to you.
- **For Communications to You.** We may communicate, electronically or via telephone, these treatment, payment or health care operation messages using telephone numbers or email addresses you provide to us.

**We may** collect, use, and disclose your health information for the following purposes under limited circumstances:

- **As Required by Law.** We may disclose information when required to do so by law.
- **To Persons Involved with Your Care.** We may collect, use and disclose your health information to a person involved in your care or who helps pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interests. Special rules apply regarding when we may disclose health information to family members and others involved in a deceased individual's care. We may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.
- **For Public Health Activities** such as reporting or preventing disease outbreaks to a public health authority.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social service or protective service agency.
- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes.** We may disclose your health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.
- **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public, by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers' Compensation** as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.
- **For Research Purposes** such as research related to the review of certain treatments or the prevention of disease or disability, if the research study meets federal privacy law requirements.
- **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as needed to carry out their duties.
- **For Organ Procurement Purposes.** We may collect, use, and disclose information to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if needed (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.



- **To Business Associates** that perform functions on our behalf or provide us with services if the information is needed for such functions or services. Our business associates are required, under contract with us, and according to federal law, to protect the privacy of your information and are not allowed to collect, use, and disclose any information other than as shown in our contract and as permitted by federal law.
- **Additional Restrictions on Use and Disclosure.** Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. Such laws may protect the following types of information:
  1. Alcohol and Substance Abuse
  2. Biometric Information
  3. Child or Adult Abuse or Neglect, including Sexual Assault
  4. Communicable Diseases
  5. Genetic Information
  6. HIV/AIDS
  7. Mental Health
  8. Minors' Information
  9. Prescriptions
  10. Reproductive Health
  11. Sexually Transmitted Diseases

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

Except for uses and disclosures described and limited as stated in this notice, we will use and disclose your health information only with a written authorization from you. This includes, except for limited circumstances allowed by federal privacy law, not using or disclosing psychotherapy notes about you, selling your health information to others, or using or disclosing your health information for certain promotional communications that are prohibited marketing communications under federal law, without your written authorization. Once you give us authorization to release your health information, we cannot guarantee that the recipient to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. To find out where to mail your written authorization and how to revoke an authorization, call the phone number listed on your health plan ID card.

## What Are Your Rights

The following are your rights with respect to your health information:

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that authorize your dependents to request certain restrictions. **Please note that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any restriction.**
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests in accordance with applicable state or federal law. In certain circumstances, we will accept your verbal request to receive confidential communications, however; we may also require you confirm your request in writing. In addition, any requests to change or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.
- **You have the right to see and get a copy** of certain health information we maintain about you such as claims and case or medical management records. If we maintain your health information electronically, you will have the right to request that we send a copy of your health information in an electronic format to you. You can also request that we provide a copy of your information to a third party that you identify. In some cases, you may receive a summary of this health information. You must make a written request to inspect

and copy your health information or have your information sent to a third party. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information. If we deny your request, you may have the right to have the denial reviewed. We may charge a reasonable fee for any copies.

- **You have the right to ask to amend** certain health information we maintain about you such as claims and case or medical management records, if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to receive an accounting** of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) for treatment, payment, and health care operations purposes; (ii) to you or according to your authorization; and (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require us to provide an accounting.
- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You also may get a copy of this notice on your health plan website, such as [www.myuhc.com](http://www.myuhc.com).
- **You have the right to make a written request that we correct or amend** your personal information. Depending on your state of domicile, you may have the right to request the deletion of your personal information. If we are unable to honor your request, we will notify you of our decision. If we deny your request, you have the right to submit to us a written statement of the reasons for your disagreement with our assessment of the disputed information and what you consider to be the correct information. We will make your statement accessible to parties reviewing the information in dispute.

## Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want information about exercising your rights, please call the toll-free member phone number on your health plan ID card or you may call us at 1-866-633-2446 or TTY/RTT711.
- **Submitting a Written Request.** You can mail your written requests to exercise any of your rights, including modifying or cancelling a confidential communication, for copies of your records, or requesting amendments to your record, to us at the following address:

UnitedHealthcare  
Customer Service - Privacy Unit  
PO Box 740815  
Atlanta, GA 30374-0815

- **Timing.** We will respond to your telephonic or written request within 30 business days of receipt.
- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the address listed above.

**You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint.** We will not take any action against you for filing a complaint.

<sup>2</sup>This Medical Information Notice of Privacy Practices applies to the following health plans that are affiliated with UnitedHealth Group: ACN Group of California, Inc.; All Savers Insurance Company; All Savers Life Insurance Company of California; AmeriChoice of New Jersey, Inc.; Arizona Physicians IPA, Inc.; Care Improvement Plus of Texas Insurance Company; Care Improvement Plus South Central Insurance Company; Care Improvement Plus Wisconsin Insurance Company; Dental Benefit Providers of California, Inc.; Dental Benefit Providers of Illinois, Inc.; Enterprise Life Insurance Company; Freedom Life Insurance Company of America; Golden Rule Insurance Company; Health Plan of Nevada, Inc.; MAMSI Life and Health Insurance Company; March Vision Care, Inc.; MCNA Insurance Company; MD - Individual Practice Association, Inc.; Medical Health Plans of Florida, Inc.; Medica HealthCare Plans, Inc.; National Foundation Life Insurance Company; National Pacific Dental, Inc.; Neighborhood Health Partnership, Inc.; Nevada Pacific Dental; Optimum Choice, Inc.; Optum Insurance Company of Ohio, Inc.; Oxford Health Insurance, Inc.; Oxford Health Plans (CT), Inc.; Oxford Health Plans (NJ), Inc.; Oxford Health Plans (NY), Inc.; PacifiCare Life and Health Insurance Company; PacifiCare Life Assurance

Company; PacifiCare of Arizona, Inc.; PacifiCare of Colorado, Inc.; PacifiCare of Nevada, Inc.; Physicians Health Choice of Texas, LLC; Preferred Care Partners, Inc.; Rocky Mountain Health Maintenance Organization, Incorporated; Sierra Health and Life Insurance Company, Inc.; (DBA UnitedHealthcare Insurance Company USA applicable to Arkansas and Maryland only); Solstice Benefits, Inc.; Solstice Health Insurance Company; Solstice Healthplans of Arizona, Inc.; Solstice Healthplans of Colorado, Inc.; Solstice Healthplans of New Jersey Inc.; Solstice Healthplans of Ohio, Inc.; Solstice Healthplans of Texas, Inc.; Solstice Healthplans, Inc.; Solstice of Illinois, Inc.; Solstice of New York, Inc.; U.S. Behavioral Health Plan, California; UHC of California; Unimerica Insurance Company; Unimerica Life Insurance Company of New York; Unison Health Plan of Delaware, Inc.; UnitedHealthcare Benefits of Texas, Inc.; UnitedHealthcare Community Plan of California, Inc.; UnitedHealthcare Community Plan of Georgia, Inc.; UnitedHealthcare Community Plan of Ohio, Inc.; UnitedHealthcare Community Plan, Inc.; UnitedHealthcare Community Plan of Texas, L.L.C.; UnitedHealthcare Freedom Insurance Company; UnitedHealthcare Insurance Company; UnitedHealthcare Insurance Company of America; UnitedHealthcare Insurance Company of Illinois; UnitedHealthcare Insurance Company of New York; UnitedHealthcare Insurance Company of the River Valley; UnitedHealthcare Integrated Services, Inc.; UnitedHealthcare Life Insurance Company; UnitedHealthcare of Alabama, Inc.; UnitedHealthcare of Arizona, Inc.; UnitedHealthcare of Arkansas, Inc.; UnitedHealthcare of Colorado, Inc.; UnitedHealthcare of Florida, Inc.; UnitedHealthcare of Georgia, Inc.; UnitedHealthcare of Illinois, Inc.; UnitedHealthcare of Kentucky, Ltd.; UnitedHealthcare of Louisiana, Inc.; HealthCare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New Mexico, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of North Carolina, Inc.; UnitedHealthcare of Ohio, Inc.; UnitedHealthcare of Oklahoma, Inc.; UnitedHealthcare of Oregon, Inc.; UnitedHealthcare of Pennsylvania, Inc.; UnitedHealthcare of Texas, Inc.; UnitedHealthcare of the Mid-Atlantic, Inc.; UnitedHealthcare of the Midlands, Inc.; UnitedHealth Care of the Midwest, Inc.; UnitedHealthcare of the Rockies, Inc.; UnitedHealthcare of Utah, Inc.; UnitedHealthcare of Washington, Inc.; UnitedHealthcare of Wisconsin, Inc.; UnitedHealthcare Plan of the River Valley, Inc. This list of health plans is complete as of the effective date of this notice. For a current list of health plans subject to this notice go to [www.uhc.com/privacy/entities-fn-v1](http://www.uhc.com/privacy/entities-fn-v1).

## **FINANCIAL INFORMATION PRIVACY NOTICE**

**THIS NOTICE DESCRIBES HOW FINANCIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. PLEASE REVIEW IT CAREFULLY.**

*Effective January 1, 2023*

We<sup>3</sup> are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information, other than health information, about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

### **Information We Collect**

Depending upon the product or service you have with us, we may collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age, medical information and *Social Security* number.
- Information about your transactions with us, our affiliates or others, such as premium payment and claims history.
- Information from a consumer reporting agency.

### **Disclosure of Information**

We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law. For example, in the course of our general business practices, we may, as permitted by law, disclose any of the personal financial information that we collect about you without your authorization, to the following types of institutions:

- To our corporate affiliates, which include financial service providers, such as other insurers, and non-financial companies, such as data processors.
- To nonaffiliated companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations.
- To nonaffiliated companies that perform services for us, including sending promotional communications on our behalf.

### **Confidentiality and Security**

We maintain physical, electronic and procedural safeguards in accordance with applicable state and federal standards to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

### **Questions about this Notice**

If you have any questions about this notice, please call the toll-free member phone number on your health plan ID card or call us at 1-866-633-2446 or TTY/RTT711.

<sup>3</sup>For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities listed in footnote 2, beginning on the first page of the Health Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliates: ACN Group of California, Inc.; AmeriChoice Health Services, Inc.; Benefitter Insurance Solutions, Inc.; Claims Management Systems, Inc.; Dental Benefit Providers, Inc.; Ear Professional International Corporation; Excelsior Insurance Brokerage, Inc.; gethealthinsurance.com Agency, Inc.; Golden Outlook, Inc.; Golden Rule Insurance Company; HealthMarkets Insurance Agency; Healthplex of CT, Inc.; Healthplex of ME, Inc.; Healthplex of NC, Inc.; Healthplex, Inc.; HealthSCOPE Benefits, Inc.; International Healthcare Services, Inc.; Level2 Health IPA, LLC; Level2 Health Management, LLC; LifePrint Health, Inc.; Managed Physical Network, Inc.; Optum Care Networks, Inc.; Optum Global Solutions (India) Private Limited; OptumHealth Care Solutions, LLC; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; POMCO Network, Inc.; POMCO, Inc.; Real Appeal, LLC; Solstice Administrators of Alabama, Inc.; Solstice Administrators of Arizona, Inc.; Solstice Administrators of Missouri, Inc.; Solstice Administrators of North Carolina, Inc.; Solstice Administrators of Texas, Inc.; Solstice Administrators, Inc.;

Solstice Benefit Services, Inc.; Solstice of Minnesota, Inc.; Solstice of New York, Inc.; Spectera, Inc.; Three Rivers Holdings, Inc.; U.S. Behavioral Health Plan, California; UHIC Holdings, Inc.; UMR, Inc.; United Behavioral Health; United Behavioral Health of New York I.P.A., Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Service LLC; Urgent Care MSO, LLC; USHEALTH Administrators, LLC; USHEALTH Group, Inc.; and Vivify Health, Inc. This Financial Information Privacy Notice only applies where required by law. Specifically, it does not apply to (1) health care insurance products offered in Nevada by Health Plan of Nevada, Inc. and Sierra Health and Life Insurance Company, Inc.; or (2) other UnitedHealth Group health plans in states that provide exceptions for HIPAA covered entities or health insurance products. This list of health plans is complete as of the effective date of this notice. For a current list of health plans subject to this notice go to [www.uhc.com/privacy/entities-fn-v1](http://www.uhc.com/privacy/entities-fn-v1).

# Statement of Employee Retirement Income Security Act of 1974 (ERISA) Rights

As a participant in the plan, you are entitled to certain rights and protections under the *Employee Retirement Income Security Act of 1974 (ERISA)*.

## Receive Information about Your Plan and Benefits

You are entitled to examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series), if applicable, filed by the plan with the *U.S. Department of Labor* and available at the *Public Disclosure Room* of the *Employee Benefits Security Administration*.

You are entitled to get, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), if applicable and updated *Summary Plan Description*. The Plan Administrator may make a reasonable charge for the copies.

## Continue Group Health Plan Coverage

You are entitled to continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the plan due to a qualifying event. You or your Dependents may have to pay for such coverage. The Plan Sponsor is responsible for providing you notice of your *Consolidated Omnibus Budget Reconciliation Act (COBRA)* continuation rights. Review the *Summary Plan Description* and the documents governing the plan on the rules governing your *COBRA* continuation coverage rights.

## Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, *ERISA* imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under *ERISA*.

## Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to get copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under *ERISA*, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$156 a day (subject to adjustment based on inflation) until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for Benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the *U.S. Department of Labor*, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

## **Assistance with Your Questions**

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the *Employee Benefits Security Administration, U.S. Department of Labor* listed in your telephone directory or the *Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor*, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also get certain publications about your rights and responsibilities under *ERISA* by calling the publication hotline of the *Employee Benefits Security Administration*.

