Certificate of Coverage
UnitedHealthcare Insurance Company

Certificate of Coverage is Part of Policy
This Certificate of Coverage (Certificate) is part of the Policy that is a legal document between UnitedHealthcare Insurance Company and the Enrolling Group to provide Benefits to Covered Persons, subject to the terms, conditions, exclusions and limitations of the Policy. We issue the Policy based on the Enrolling Group’s application and payment of the required Policy Charges.

In addition to this Certificate the Policy includes:

- The Group Policy.
- The Schedule of Benefits.
- The Enrolling Group’s application.
- Riders, including the Outpatient Prescription Drug Rider, the Pediatric Dental Services Rider, and the Pediatric Vision Care Services Rider.
- Amendments.

You can review the Policy at the office of the Enrolling Group during regular business hours.

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

No one can make any changes to the Policy unless those changes are in writing.

Other Information You Should Have
We have the right to change, interpret, modify, withdraw or add Benefits, or to terminate the Policy, as permitted by law, without your approval. However, please note that all decisions made by us are subject to the procedures described in Section 6: Questions, Complaints and Appeals.

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 specified in the Policy. Coverage under the Policy will begin at 12:01 a.m. and end at 12:00 midnight in the time zone of the Enrolling Group’s location. The Policy will remain in effect as long as the Policy Charges are paid when they are due, subject to termination of the Policy.

We are delivering the Policy in the State of Maine. The Policy is governed by ERISA unless the Enrolling Group is not an employee welfare benefit plan as defined by ERISA. To the extent that state law applies, the laws of the State of Maine are the laws that govern the Policy.
Introduction to Your Certificate

We are pleased to provide you with this Certificate. This Certificate and the other Policy documents describe your Benefits, as well as your rights and responsibilities, under the Policy.

How to Use this Document

We encourage you to read your Certificate and any attached Riders and/or Amendments carefully.

We especially encourage you to review the Benefit limitations of this Certificate by reading the attached Schedule of Benefits along with Section 1: Covered Health Services and Section 2: Exclusions and Limitations. You should also carefully read Section 8: General Legal Provisions to better understand how this Certificate and your Benefits work. You should call us if you have questions about the limits of the coverage available to you.

Many of the sections of this Certificate are related to other sections of the document. You may not have all of the information you need by reading just one section. We also encourage you to keep your Certificate and Schedule of Benefits and any attachments in a safe place for your future reference.

If there is a conflict between this Certificate and any summaries provided to you by the Enrolling Group, this Certificate will control.

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

Information about Defined Terms

Because this Certificate is part of a legal document, 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 Section 9: Defined Terms. You can refer to Section 9: Defined Terms as you read this document to have a clearer understanding of your Certificate.

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.

Don’t Hesitate to Contact Us

Throughout the document you will find statements that encourage you to contact us for further information. Whenever you have a question or concern regarding your Benefits, please call us using the telephone number for Customer Care listed on your ID card. It will be our pleasure to assist you.
Your Responsibilities

Be Enrolled and Pay Required Contributions
Benefits are available to you only 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 with us and receive Benefits, both of the following apply:

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

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

Be Aware this Benefit Plan Does Not Pay for All Health Services
Your right to Benefits is limited to Covered Health Services. The extent of this Benefit plan's payments for Covered Health Services and any obligation that you may have to pay for a portion of the cost of those Covered Health Services is set forth in the Schedule of Benefits.

Decide What Services You Should Receive
Care decisions are between you and your Physicians. 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 care to you. 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 Services require prior authorization. In general, 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 Services from a non-Network provider, you are responsible for obtaining prior authorization before you receive the services. For detailed information on the Covered Health Services that require prior authorization, please refer to the Schedule of Benefits.

Pay Your Share
You must meet any applicable deductible and pay a Copayment and/or Coinsurance for most Covered Health Services. These payments are due at the time of service or when billed by the Physician, provider or facility. Any applicable deductible, Copayment and Coinsurance amounts are listed in the Schedule of Benefits. You must also pay any amount that exceeds Eligible Expenses.

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 this Benefit plan's exclusions.
Show Your ID Card
You should show your identification (ID) card every time you request health services. If you do not show your ID card, the provider may fail to bill the correct entity for the services delivered, and any resulting delay may mean that you will be unable to collect any Benefits otherwise owed to you.

File Claims with Complete and Accurate Information
When you receive Covered Health Services from a non-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 services for that condition or disability until the prior coverage ends. We will pay Benefits as of the day your coverage begins under this Benefit plan for all other Covered Health 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 this Benefit plan 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 discretion 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 delegate this discretionary authority to other persons or entities that may provide administrative services for this Benefit plan, such as claims processing. The identity of the service providers and the nature of their services may be changed from time to time in our discretion. In order to receive Benefits, you must cooperate with those service providers.

Pay for Our Portion of the Cost of Covered Health Services
We pay Benefits for Covered Health Services as described in Section 1: Covered Health 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 Services. It also means that not all of the health care services you receive may be paid for (in full or in part) by this Benefit plan.

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

Pay for Covered Health Services Provided by Non-Network Providers
In accordance with any state prompt pay requirements, we will 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 in accordance with one or more of the following methodologies:
• As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS).
• As reported by generally recognized professionals or publications.
• As used for Medicare.
• As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that 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, non-Network providers are not subject to this
prohibition, and 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 obtain copies of our reimbursement policies for yourself or to share with your non-Network Physician or provider by going to www.myuhc.com or by calling Customer Care at the telephone number on your ID card.

**Offer Health Education Services to You**

From time to time, 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 participate in the programs, but we recommend that you discuss them with your Physician.
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Section 1: Covered Health Services

Benefits for Covered Health Services

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

- The health care service, supply or Pharmaceutical Product is only a Covered Health Service if it is Medically Necessary Health Care. (See definitions of Medically Necessary Health Care and Covered Health Service in Section 9: Defined Terms.) 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 Service under the Policy.

- Covered Health Services are received while the Policy is in effect.

- Covered Health Services are received 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 Services is a Covered Person and meets all eligibility requirements specified in the Policy.

This section describes Covered Health 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 Services (including any Annual Deductible, Copayment and/or Coinsurance).

- Any limit that applies to these Covered Health Services (including visit, day and dollar limits on services).

- Any limit that applies to the amount you are required to pay in a year (Out-of-Pocket Maximum).

- 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 Emergency Health Services can be performed.

Non-Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as we determine appropriate) between facilities when the transport is any of the following:

- From a non-Network Hospital to a Network Hospital.
- To a Hospital that provides a higher level of care that was not available at the original Hospital.
- To a more cost-effective acute care facility.
- From an acute facility to a sub-acute setting.

2. Autism Spectrum Disorder Treatment for Children Age Ten and Under

For children age ten and under, Benefits are provided for therapy services provided by a licensed or certified speech therapist, occupational therapist or physical therapist for the treatment of Autism Spectrum Disorders.
Benefits for the psychiatric component of treatment for Autism Spectrum Disorders is described under Neurobiological Disorders - Autism Spectrum Disorder Services in Section 1: Covered Health Services.

3. Children's Early Intervention Services
Benefits for children's early intervention services are available for Enrolled Dependent children from birth to 36 months of age.

For purposes of this Benefit, "Children's Early Intervention Services" means services provided by licensed occupational therapists, physical therapists, speech-language pathologists or clinical social workers working with children with an identified developmental disability or delay as described under Part C of the federal Individuals with Disabilities Education Act.

4. Clinical Trials
Routine patient care costs incurred during participation in a qualifying clinical trial for the treatment of:

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

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

Benefits are available only when the Covered Person is clinically eligible for participation in the qualifying clinical trial as defined by the researcher and meets the following conditions:

- The Covered Person has a life-threatening illness for which no standard treatment is effective.
- The Covered Person is eligible to participate according to the clinical trial protocol with respect to treatment of such illness.
- The Covered Person's participation in the trial offers meaningful potential for significant clinical benefit to the Covered Person.
- The Covered Person's referring Physician has concluded that the Covered Person's participation in such a trial would be appropriate based upon the satisfaction of the above conditions.

Routine patient care costs for qualifying clinical trials include:

- Covered Health Services for which Benefits are typically provided absent a clinical trial.
- Covered Health Services required solely for the provision of the 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 Services needed for reasonable and necessary care arising from the provision of an Experimental or Investigational Service(s) or item.

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 satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

With respect to cancer or other life-threatening diseases or conditions, a qualifying clinical trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and which meets any of the following criteria in the bulleted list below.

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

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - National Institutes of Health (NIH) or a cooperative group or center of the NIH. (Includes National Cancer Institute (NCI).)
  - Federal Department of Health and Human Services (DHHS).
  - 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 as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to meet both of the following criteria:
    - Comparable to the system of peer review of studies and investigations used by the National Institutes of Health.
    - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

- The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. 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 Service and is not otherwise excluded under the Policy.
5. Congenital Heart Disease Surgeries

Congenital heart disease (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 and hypoplastic left or right heart syndrome.

Benefits under this section 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.

We have specific guidelines regarding Benefits for CHD services. Contact us at the telephone number on your ID card for information about these guidelines.

6. Dental Anesthesia Services

Benefits are available for general anesthesia and associated facility charges for dental procedures rendered in a hospital for certain Covered Persons when the clinical status or underlying medical condition of such Covered Persons requires dental procedures that ordinarily would not require general anesthesia to be rendered in a hospital.

This section applies only to Covered Persons who meet the following criteria:

- Covered Persons, including infants, exhibiting physical, intellectual or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities, can be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to produce a superior result;
- Covered Persons demonstrating dental treatment needs for which local anesthesia is ineffective because of acute infection, anatomic variation or allergy;
- Extremely uncooperative, fearful, anxious or uncommunicative children or adolescents with dental needs of such magnitude that treatment should not be postponed or deferred and for whom lack of treatment can be expected to result in dental or oral pain or infection, loss of teeth or other increased oral or dental morbidity; and
- Covered Persons who have sustained extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised.

7. Dental Services - Accident Only

Dental services when all of the following are true:

- **Treatment is necessary because of accidental damage.**
- **Dental services are received from a Doctor of Dental Surgery, Doctor of Medical Dentistry or licensed independent practice dental hygienist.**
- **The dental damage is severe enough that initial contact with a Physician, dentist or licensed independent practice dental hygienist occurred within 72 hours of the accident. (You may request an extension of this time period provided that 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 occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered having occurred as an accident. 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 conform to the following time-frames:

- **Treatment is started within three months of the accident, 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.**
Benefits for treatment of accidental Injury are limited to the following:

- Emergency examination.
- Necessary 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 the Injury by implant, dentures or bridges.

Note: When services are provided by an independent practice dental hygienist, such services are limited to those provided within the scope of practice of the independent practice dental hygienist.

8. Diabetes Services

Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Diabetes outpatient self-management training, education and medical nutrition therapy services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals including outpatient self-management training and education services provided through ambulatory diabetes education facilities authorized by the Maine Diabetes Control Project within the Bureau of Health.

Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes.

Diabetic Self-Management Items and Medications

Insulin pumps and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person. An insulin pump is subject to all the conditions of coverage stated under Durable Medical Equipment. Benefits for insulin, oral hypoglycemic agents, blood 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 the Outpatient Prescription Drug Rider.

- Insulin.
- Oral hypoglycemic agents.
- Insulin pumps are subject to all the conditions of coverage stated under Durable Medical Equipment.
- Blood glucose monitors.
- Insulin syringes with needles.
- Blood glucose and urine test strips.
- Ketone test strips and tablets.
- Lancets and lancet devices.

9. Durable Medical Equipment

Durable Medical Equipment that meets each of the following criteria:

- 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 Durable Medical Equipment.
• Not of use to a person in the absence of a disease or disability.

Benefits under this section include Durable Medical Equipment provided to you by a Physician.

If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the equipment that meets the minimum specifications for your needs.

Examples of Durable Medical Equipment include:
• Equipment to assist 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).
• Delivery pumps for tube feedings (including tubing and connectors).
• Negative pressure wound therapy pumps (wound vacuums).
• Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. Dental braces are also excluded from coverage.
• Mechanical equipment necessary for the treatment of chronic or acute 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 necessary 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 under this section also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required three-month rental period. Benefits are limited as stated in the Schedule of Benefits.

Benefits under this section do not include any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body.

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

Benefits are available for repairs and replacement, except that:
• Benefits for repair and replacement do not apply to damage due to misuse, malicious breakage or gross neglect.
• Benefits are not available to replace lost or stolen items.

10. Emergency Health Services - Outpatient
Services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility.
Benefits under this section include the facility charge, supplies and all professional services required to stabilize your condition and/or initiate treatment. This includes placement in an observation bed for the purpose of monitoring your condition (rather than being admitted to a Hospital for an Inpatient Stay).

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

11. Family Planning
Benefits for family planning and contraceptives approved by the Food and Drug Administration (FDA) to prevent pregnancy, including related consultations, examinations, procedures and medical services provided on an outpatient basis.

12. 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). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Physician or state licensed audiologist. Benefits are provided for a hearing aid for each hearing impaired ear and for charges for associated fitting 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.

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

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

13. Home Health Care
Services received from a Home Health Agency that are both 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.

Benefits are available only when the Home Health Agency services are provided on a part-time, Intermittent Care schedule and when skilled care is required.

Skilled care is skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true:

- It 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.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not 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. A service will not be determined to be "skilled" simply because there is not an available caregiver.

In accordance with state law, Home Health Care services include the following:

- Visits by a registered nurse or licensed practical nurse to carry out treatments prescribed, or supportive nursing care and observation as indicated.
- A Physician's home or office visits or both.
- Visits by a registered physical, speech, occupational, inhalation or dietary therapist for services or for evaluation of, consultation with and instruction of nurses in carrying out such therapy prescribed by the attending physician, or both.
- Any prescribed laboratory tests and x-ray examination using hospital or community facilities, drugs, dressings, oxygen or medical appliances and equipment as prescribed by a Physician, but only to the extent that such charges would have been covered under the Policy if the Covered Person had remained in the Hospital.
- Visits by persons who have completed a home health aide training course under the supervision of a registered nurse for the purpose of giving personal care to the patient and performing light household tasks as required by the plan of care, but not including services.

There is no requirement that hospitalization be an antecedent to Benefits for Home Health Agency services under the Policy.

14. 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. Hospice care includes physical, psychological, social, spiritual and respite care for the terminally ill person and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available when hospice care is received from a licensed hospice agency.

Hospice care services must be provided according to a written care delivery plan developed by a hospice care provider and the recipient of the Hospice Care services. Benefits are available for Hospice Care services whether the services are provided in a home setting or an inpatient setting. Hospice Care services includes, but is not limited to, Physician's services; nursing care; respite care; medical and social work services; counseling services; nutritional counseling; pain and symptom management; medical supplies and durable medical equipment; occupational, physical or speech therapies; volunteer services; home health care services; and bereavement services.

Please contact us for more information regarding our guidelines for hospice care. You can contact us at the telephone number on your ID card.

15. 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).
- Benefits include medically appropriate inpatient coverage following a mastectomy, a lumpectomy or a lymph node dissection for the treatment of breast cancer including breast reconstruction procedures for the period of time determined by the attending Physician in consultation with the Covered Person. Breast reconstruction benefits are described under Reconstructive Procedures below.
- 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.)
16. **Infant Formula**

Coverage is provided for medically necessary amino acid-based elemental infant formula for children two years of age and under without regard to the method of delivery of the formula. Provided that the requirement of "medical necessity" described below is met, this coverage will be provided when a licensed Physician has diagnosed, and through medical evaluation has documented, one of the following conditions:

- Symptomatic allergic colitis or proctitis.
- Laboratory or biopsy-proven allergic or eosinophilic gastroenteritis.
- A history of anaphylaxis.
- Gastroesophageal reflux disease that is non-responsive to standard medical therapies.
- Severe vomiting or diarrhea resulting in clinically significant dehydration requiring medical treatment.
- Cystic fibrosis.
- Malabsorption of cow milk-based or soy milk-based infant formula.

In addition to meeting the conditions stated in the definition of the term Medically Necessary Health Care as defined in Section 9: Defined Terms, amino acid-based elemental infant formula will be considered "medically necessary" when the following conditions are met:

- The amino acid-based elemental infant formula is the predominant source of nutritional intake at a rate of 50% or greater; and
- Other commercial infant formulas including cow milk-based and soy milk-based formulas have been tried and have failed or are contraindicated.

We may require that a licensed Physician confirm and document ongoing medical necessity at least once a year.

17. **Lab, X-Ray and Diagnostics - 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, including human leukocyte antigen testing performed to establish bone marrow transplantation suitability, and radiology/X-ray.
- Mammography.

Benefits under this section 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.)

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 Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient.

18. **Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - 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 under this section 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. Medical Foods
Benefits are available for metabolic formula and special modified low-protein food products that have been prescribed by a licensed physician for a person with an inborn error of metabolism.

As used in this section, "inborn error of metabolism" means a genetically determined biochemical disorder in which a specific enzyme defect produces a metabolic block that may have pathogenic consequences at birth or later in life. As used in this section, "special modified low-protein food product" means food formulated to reduce the protein content to less than one gram of protein per serving and does not include foods naturally low in protein.

20. Mental Health Services
Mental Health Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility or in a provider's office. Outpatient Mental Health Services include screening, evaluation, consultations, diagnosis and treatment involving use of psychoeducational, physiological, psychological and psychosocial evaluative and interventional concepts, techniques and processes provided to individuals and groups. Inpatient Mental Health Services include a range of physiological, psychological and other intervention concepts, techniques and processes in a community mental health psychiatric inpatient unit, general hospital psychiatric unit or psychiatric hospital licensed by the Department of Human Services or an accredited public hospital to restore psychosocial functioning sufficient to allow maintenance and support of the client in a less restrictive setting.

Benefits described in this section include Mental Health Services for the treatment of Biologically-based Mental illnesses including psychotic disorders, including schizophrenia; dissociative disorders; mood disorders; anxiety disorders; personality disorders; paraphilias; attention deficit and disruptive behavior disorders; tic disorders; and eating disorders, including bulimia and anorexia. Benefits for the treatment of pervasive developmental disorders are described under *Neurobiological Disorders - Autism Spectrum Disorder Services.* Benefits for the treatment of substance use disorders are described under *Substance Use Disorder Services.*

Benefits include the following services:
- Diagnostic evaluations and assessment.
- Treatment planning.
- Treatment and/or procedures.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.
- Partial Hospitalization/Day Treatment.
- Services at a Residential Treatment Facility.
- Intensive Outpatient Treatment.

Outpatient Benefits are also available for home health care services which means those services rendered by a licensed provider of Mental Health Services to provide Medically Necessary Health Care to a person suffering from a Mental Illness in the person’s place of residence if:
- Hospitalization or confinement in a Residential Treatment Facility would otherwise have been required if home health care services were not provided.
• The services are prescribed in writing by a licensed allopathic or osteopathic Physician or a licensed psychologist who is trained and has received a doctorate in psychology specializing in the evaluation and treatment of Mental Illness.

There is no requirement that hospitalization or confinement in a Residential Treatment Facility be an antecedent to Home Health Care Coverage under the Policy.

The Mental Health/Substance Use Disorder Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

We encourage you to contact the Mental Health/Substance Use Disorder Designee for referrals to providers and coordination of care.

Special Mental Health Programs and Services

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Designee may become available to you as a part of your Mental Health Services Benefit. The Mental Health Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your Mental Illness which may not otherwise be covered under the Policy. You must be referred to such programs through the Mental Health/Substance Use Disorder Designee, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.

21. Neurobiological Disorders - Autism Spectrum Disorder Services

Psychiatric services for Autism Spectrum Disorder (otherwise known as neurodevelopmental disorders) that are both of the following:

• Provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider.

• 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 psychiatric component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Service for which Benefits are available as described under Autism Spectrum Disorder Treatment for Children Age Ten and Under in Section 1: Covered Health Services of this Certificate.

Benefits include the following services provided on either an inpatient or outpatient basis:

• Diagnostic evaluations and assessment.

• Treatment planning.

• Treatment and/or procedures.

• Referral services.

• Medication management.

• Individual, family, therapeutic group and provider-based case management services.

• Crisis intervention.

• Partial Hospitalization/Day Treatment.

• Services at a Residential Treatment Facility.

• Intensive Outpatient Treatment.
For children age ten and under, Benefits are provided for enhanced Autism Spectrum Disorder services that are focused on educational/behavioral intervention that are habilitative in nature and that are backed by credible research demonstrating that the services or supplies have a measurable and beneficial effect on health outcomes. Benefits are provided for intensive behavioral therapies (educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning such as Applied Behavioral Analysis (ABA)). ABA means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior. In order to be eligible for Benefits, ABA must be provided by a person professionally certified by a national board of behavior analysts or performed under the supervision of a person professionally certified by a national board of behavior analysts.

Benefits for therapy services provided by a licensed or certified speech therapist, occupational therapist or physical therapist are described under Autism Spectrum Disorder Treatment for Children Age Ten and Under in Section 1: Covered Health Services.

The Mental Health/Substance Use Disorder Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

We encourage you to contact the Mental Health/Substance Use Disorder Designee for referrals to providers and coordination of care.

22. Obesity Surgery
Surgical treatment of obesity when provided by or under the direction of a Physician when the Covered Person has been diagnosed as morbidly obese for a minimum of five consecutive years. Benefits are limited to surgery for an intestinal bypass, gastric bypass or gastroplasty. Benefits for obesity surgery are provided as stated in the Schedule of Benefits under Obesity Surgery.

23. 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.

24. Parenteral and Enteral Therapy
Benefits for supplies and equipment needed to appropriately administer parenteral and enteral therapy are covered. Nutritional supplements for the sole purpose of enhancing dietary intake are not covered unless they are given in conjunction with enteral therapy.

25. Pharmaceutical Products - Outpatient
Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy.

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 through the Internet at www.myuhc.com or by calling Customer Care at the telephone number on your ID card.

26. Physician Fees for Surgical and Medical Services
Physician fees for surgical procedures and other medical care received on an outpatient or inpatient basis in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility, Alternate Facility, via Telemedicine or for Physician house calls.

In-person consultation is not required between a Physician and a Covered Person for services to be appropriately provided by Telemedicine. Services provided by Telemedicine are subject to the same terms and conditions of the Policy for any service provided via an in-person consultation.

27. 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 under this section regardless of whether the Physician's office is free-standing, located in a clinic or located in a Hospital.

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

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

Benefits under this section include approved asthma education programs.

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing which is determined to be Medically Necessary Health Care following genetic counseling when ordered by the Physician and authorized in advance by us.

Benefits under this section include allergy injections.

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

When a test is performed or a sample is drawn in the Physician's office and then sent outside the Physician's office for analysis or testing, Benefits for lab, radiology/X-rays and other diagnostic services that are performed outside the Physician's office are described in Lab, X-ray and Diagnostics - Outpatient.

28. 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 Services include related tests and treatment.

We also have special prenatal programs to help during Pregnancy. They are completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify us during the first trimester, but no later than one month prior to the anticipated childbirth. It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs designed to achieve the best outcomes for you and your baby.

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.

29. 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.

- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, the United States Department of Health and Human Services and the American Academy of Pediatrics.

- 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, including screening mammograms and annual gynecological exams, including routine pelvic and clinical breast examinations and screening Pap tests. Benefits for screening mammograms include one screening mammogram per year for women 40 years of age and over.

For purposes of this Benefit, a "screening mammogram" means a radiologic procedure that is provided to asymptomatic women for the purpose of early detection of breast cancer and that consists of 2 radiographic views per breast. A screening mammogram also includes an additional radiologic procedure recommended by a provider when the results of an initial radiologic procedure are not definitive.

Benefits defined under the Health Resources and Services Administration (HRSA) requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Breast pumps must be ordered by or provided by a Physician. You can obtain additional information on how to access Benefits for breast pumps by going to www.myuhc.com or by calling Customer Care at 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.
- Duration of a rental.
- Timing of an acquisition.

- Colorectal cancer screenings including coverage for asymptomatic individuals who are:
  - 50 years of age or older; or
  - Less than 50 years of age and at high risk for colorectal cancer according to the most recently published colorectal cancer screening guidelines of a national cancer society.

For purposes of this benefit, "colorectal cancer screening" means a colorectal cancer examination and laboratory test recommended by a health care provider in accordance with the most recent published colorectal cancer screening guidelines of a national cancer society.

- Prostate cancer screening, including a digital rectal examination and a prostate-specific antigen test.
30. **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 and lymphedema stockings for the arm.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body.

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 that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices.

31. **Reconstructive Procedures**
Reconstructive procedures when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not 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 a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

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 Service. You can contact us at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

32. **Rehabilitation Services - Outpatient Therapy and Manipulative Treatment**
Short-term outpatient rehabilitation services (including habilitative 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.

Massage therapy when part of an active course of treatment and performed by an eligible provider. Massage therapists are not considered eligible providers.

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed Manipulative Treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive Manipulative Treatment.

Habilitative Services

Benefits are provided for habilitative services provided on an outpatient basis for Covered Persons with a congenital, genetic, or early acquired disorder when both of the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist, Physician, licensed nutritionist, licensed social worker or licensed psychologist.

- The initial or continued treatment must be proven and not Experimental or Investigational.

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and residential treatment are not habilitative services.

A service that does not help the Covered Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service. When the Covered Person reaches his/her maximum level of improvement or does not demonstrate continued progress under a treatment plan, a service that was previously habilitative is no longer habilitative.

We may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow us to substantiate that initial or continued medical treatment is needed and that the Covered Person's condition is clinically improving as a result of the habilitative service. When the treating provider anticipates that continued treatment is or will be required to permit the Covered Person to achieve demonstrable progress, we may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

For purposes of this benefit, the following definitions apply:

- "Habilitation services" means occupational therapy, physical therapy and speech therapy prescribed by the Covered Person's treating Physician pursuant to a treatment plan to develop a function not currently present as a result of a congenital, genetic, or early acquired disorder.

- A "congenital or genetic disorder" includes, but is not limited to, hereditary disorders.

- An "early acquired disorder" refers to a disorder resulting from Sickness, Injury, trauma or some other event or condition suffered by a Covered Person prior to that Covered Person developing functional life skills such as, but not limited to, walking, talking, or self-help skills.

Habilitation services performed as part of a certified Early Intervention Services program as stated in the Certificate and Schedule of Benefits under Children's Early Intervention Services are not subject to the annual visit limits as stated in the Certificate and Schedule of Benefits under either Rehabilitation Services - Outpatient Therapy or under Therapeutic, Adjustive and Manipulative Services.

Habilitation services performed as stated in the Certificate and Schedule of Benefits under Neurobiological Disorders - Autism Spectrum Disorder Services and Autism Spectrum Disorder...
Treatment for Children Age Ten and Under are not subject to the annual visit limits as stated in the Certificate and Schedule of Benefits under either Rehabilitation Services - Outpatient Therapy or under Therapeutic, Adjustive and Manipulative Services.

Other than as described under Habilitative Services above, please note that we will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorder. We will pay Benefits for cognitive rehabilitation therapy only when it is Medically Necessary Health Care following a post-traumatic brain Injury or cerebral vascular accident.

33. **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 and endoscopy.

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under Surgery - Outpatient. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Benefits under this section 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.)

When these services are performed for preventive screening purposes, Benefits are described under Preventive Care Services.

34. **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 initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a cost effective alternative to an Inpatient Stay in a Hospital.
- You will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true:

- It 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.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

35. Smoking Cessation
Coverage is provided for smoking cessation programs including both educational and medical treatments to help a person overcome nicotine addiction. Qualifying programs must be recommended by a Physician who follows the United States Public Health Service guidelines. Depending on where the smoking cessation program is administered, Benefits will be the same as stated under each Covered Health Service category in the Schedule of Benefits.

36. Substance Use Disorder Services
Substance Use Disorder Services (also known as 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.

Benefits include the following services:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Treatment and/or procedures.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.
- Partial Hospitalization/Day Treatment.
- Services at a Residential Treatment Facility.
- Intensive Outpatient Treatment.

Substance Use Disorder Services includes care rendered by a state-licensed, approved or certified detoxification, residential treatment program, or partial hospitalization program on a periodic basis, including, but not limited to, patient diagnosis, assessment and treatment, individual, family and group counseling and educational and support services.

Benefits are available for Substance Use Disorder Services for Residential Treatment at a facility that provides care 24 hours daily to one or more patients. The term "Residential Treatment" includes, but is not limited to the following services: room and board; medical, nursing and dietary services; patient diagnosis, assessment and treatment; individual, family and group counseling; and educational and support services, including a designated unit of a licensed health care facility providing any and all other services specified in this paragraph to patients with the illnesses of alcoholism and drug dependency.

The Mental Health/Substance Use Disorder Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

We encourage you to contact the Mental Health/Substance Use Disorder Designee for referrals to providers and coordination of care.

Special Substance Use Disorder Programs and Services
Special programs and services that are contracted under the Mental Health/Substance Use Disorder Designee may become available to you as a part of your Substance Use Disorder Services Benefit. The
Substance Use Disorder Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your substance use disorder which may not otherwise be covered under the Policy. You must be referred to such programs through the Mental Health/Substance Use Disorder Designee, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.

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

Benefits under this section include certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

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

Benefits under this section 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.)

38. Therapeutic, Adjustive and Manipulative Services
Benefits for therapeutic, adjustive and manipulative services when performed by a chiropractic, allopathic or osteopathic doctor in the provider's office.

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

39. 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 and radiation oncology.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when both of the following are true:
- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section 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.

40. Transplantation Services
Organ and tissue transplants when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational or Unproven Service.
Examples of transplants for which Benefits are available include bone marrow, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.

Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Policy.

We have specific guidelines regarding Benefits for transplant services. Contact us at the telephone number on your ID card for information about these guidelines.

Bone marrow transplants that are not a Covered Health Service are those that are specifically excluded from coverage in Section 2: Exclusions and Limitations, or those that meet the definition of Experimental or Investigational Services in Section 9: Defined Terms.

41. Urgent Care Center Services
Covered Health 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.

42. Vision Correction After Surgery or Accident
Benefits for vision correction after surgery or accident are provided for the prescription, fitting or purchase of glasses or contact lenses. Coverage is provided as necessary to treat accommodative strabismus, cataracts, or aphakia.

Benefits are provided as stated under Durable Medical Equipment in the Schedule of Benefits.
Section 2: Exclusions and Limitations

How We Use Headings in this Section
To help you find specific exclusions more easily, we use headings (for example A. Alternative Treatments below). The headings group services, treatments, items, or supplies that fall into a similar category. Actual exclusions appear underneath headings. A heading does not create, define, modify, 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 Services, except as may be specifically provided for in Section 1: Covered Health Services or through a Rider to the Policy.

Benefit Limitations
When Benefits are limited within any of the Covered Health Service categories described in Section 1: Covered Health Services, those limits are stated in the corresponding Covered Health Service category in the Schedule of Benefits. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in the Schedule of Benefits under the heading Benefit Limits. 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 except as described under Rehabilitation Services - Outpatient Therapy and Manipulative Treatment in Section 1: Covered Health Services.
5. Rolfing.
6. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) 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 Services.

B. Dental
1. Dental care (which includes dental X-rays, supplies and appliances and all associated 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 in Section 1: Covered Health Services.
The above exclusion of hospitalization and anesthesia expenses does not apply to dental-related services for which Benefits are provided as described under Dental Anesthesia Services in Section 1: Covered Health Services.

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

- Transplant preparation.
- Prior to the initiation of immunosuppressive drugs.
- The direct treatment of acute traumatic injury, cancer or cleft palate.

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

Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:
   - Extraction, restoration and replacement of teeth.
   - Medical or surgical treatments of dental conditions.
   - Services to improve dental clinical outcomes.

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 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 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 specifically as safety items or to affect 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 Covered Health Services as described under Orthotic Devices in Section 1: Covered Health 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 assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under Durable Medical Equipment in Section 1: Covered Health Services.

5. Oral appliances for snoring.
6. Repairs to prosthetic devices due to misuse, malicious damage or gross neglect.
7. Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

D. Drugs
1. Prescription drug products for outpatient use that are filled by a prescription order or refill.
2. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.
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 consumed in the Physician’s office.
4. Over-the-counter drugs and treatments.
5. Growth hormone therapy.
6. Off-label use of prescription drugs except for the diagnosis of cancer, HIV or AIDS.

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 Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in Section 1: Covered Health Services.

F. Foot Care
1. Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under Diabetes Services in Section 1: Covered Health Services.
2. Nail trimming, cutting, or debriding.
3. Hygienic and preventive maintenance foot care. Examples include:
   - Cleaning and soaking the feet.
   - Applying skin creams in order to maintain skin tone.

This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.
4. Treatment of flat feet.
5. Treatment of subluxation of the foot.
7. Shoe orthotics.
8. Shoe inserts.

G. Medical Supplies
1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
   - Compression stockings.
- Ace bandages.
- Gauze and dressings.
- Urinary catheters.

This exclusion does not apply to:
- Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under Durable Medical Equipment in Section 1: Covered Health Services.
- Diabetic supplies for which Benefits are provided as described under Diabetes Services in Section 1: Covered Health Services.
- Ostomy supplies for which Benefits are provided as described under Ostomy Supplies in Section 1: Covered Health Services.

2. Tubings and masks except when used with Durable Medical Equipment as described under Durable Medical Equipment in Section 1: Covered Health Services.

H. Mental Health
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 Services in Section 1: Covered Health Services.

1. Services performed in connection with conditions not classified in the most recent revised publication or most updated volume of the Diagnostic and Statistical Manual (“DSM”) published by the American Psychiatric Association or the International Classification of Disease Manual (“ICO”) published by the World Health Organization.

2. Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act.

3. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 9: Defined Terms. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:
   - Medically Necessary Health Care.
   - Described as a Covered Health Service in this Policy under Section 1: Covered Health Services and in the Schedule of Benefits.
   - Not otherwise excluded in this Policy under Section 2: Exclusions and Limitations.

I. Neurobiological Disorders - Autism Spectrum Disorder
In addition to all other exclusions listed in this Section 2: Exclusions and Limitations, the exclusions listed directly below apply to services described under Neurobiological Disorders - Autism Spectrum Disorder Services in Section 1: Covered Health Services.

1. Services as treatments of sexual dysfunction and feeding disorders as listed in the most recent revised publication or most updated volume of the Diagnostic and Statistical Manual (“DSM”) published by the American Psychiatric Association or the International Classification of Disease Manual (“ICO”) published by the World Health Organization.

2. Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.

3. Intellectual disability as the primary diagnosis defined in the DSM or ISO.
4. Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.

5. Learning, motor disorders and communication disorders as defined in the current edition of the *DSM* or *ISO* and which are not a part of Autism Spectrum Disorder.

6. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilic disorder.

7. All unspecified disorders in the current edition of the *DSM* or *ISO*.

8. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 9: Defined Terms. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:
   - Medically Necessary Health Care.
   - Described as a Covered Health Service in this Policy under Section 1: Covered Health Services and in the Schedule of Benefits.
   - Not otherwise excluded in this Policy under Section 2: Exclusions and Limitations.

**J. Nutrition**

1. Individual and group nutritional counseling except as described under Diabetes Services and Hospice Care in Section 1: Covered Health Services. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:
   - Nutritional education is required for a disease in which patient self-management is an important component of treatment.
   - There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

2. Infant formula and donor breast milk except as described under Medical Foods and Infant Formula in Section 1: Covered Health 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, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods).

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

1. Television.

2. Telephone.


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 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.
   - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
   - Treatment for spider veins.
   - Hair removal or replacement by any means.

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 initial breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Services*.

3. **Treatment of benign gynecomastia** (abnormal breast enlargement in males).

4. **Physical conditioning programs** such as athletic training, body-building, exercise, fitness, flexibility and diversion or general motivation.
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.

**M. Procedures and Treatments**

1. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy 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 to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment.

5. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorder.

6. Outpatient cognitive rehabilitation therapy except for Medically Necessary Health Care following a post-traumatic brain Injury or cerebral vascular accident.

7. Psychosurgery.

8. Sex transformation operations and related services.

9. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.


11. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature.

12. Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for Covered Persons because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea.

13. Surgical treatment of obesity unless it is deemed Medically Necessary Health Care.


15. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings. This exclusion does not apply to the Benefits described under Smoking Cessation in Section 1: Covered Health Services.

16. 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 Services.

17. In vitro fertilization regardless of the reason for treatment.

**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 residence.
3. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:
   - Has not been actively involved in your medical care prior to ordering the service, or
   - Is not actively involved in your medical care after the service is received.

This exclusion does not apply to mammography.

O. Reproduction
1. Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility.
2. Surrogate parenting, donor eggs, donor sperm and host uterus.
3. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.
4. The reversal of voluntary sterilization.

P. Services Provided under another Plan
1. Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. Examples include coverage required by workers’ compensation, no-fault auto insurance, or similar legislation. However, coverage is provided for conditions that occurred at work if the claim is controverted.
   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. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
3. Health services while on active military duty.

Q. Substance Use 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 Substance Use Disorder Services in Section 1: Covered Health Services.
1. Services performed in connection with conditions not classified in the most recent revised publication or most updated volume of the Diagnostic and Statistical Manual ("DSM") published by the American Psychiatric Association or the International Classification of Disease Manual ("ICO") published by the World Health Organization.
2. Gambling disorders.
3. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 9: Defined Terms. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:
   - Medically Necessary Health Care.
   - Described as a Covered Health Service in this Policy under Section 1: Covered Health Services and in the Schedule of Benefits.
Not otherwise excluded in this Policy under Section 2: Exclusions and Limitations.

R. Transplants
1. Health services for organ and tissue transplants, except those described under Transplantation Services in Section 1: Covered Health Services.
2. Health 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 services for transplants involving permanent mechanical or animal organs.
4. Transplant services that are not performed at a Designated Facility. This exclusion does not apply to cornea transplants.

S. Travel
1. Health services provided in a foreign country, unless required as Emergency Health Services.
2. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at our discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under Ambulance Services in Section 1: Covered Health Services.

T. Types of Care
1. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.
2. Custodial Care or maintenance care.
3. Domiciliary care.
4. Private Duty Nursing.
5. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under Hospice Care in Section 1: Covered Health Services.
6. Rest cures.
7. Services of personal care attendants.
8. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

U. Vision and Hearing
1. Purchase cost and fitting charge for eyeglasses and contact lenses. This exclusion does not apply to Benefits described under Vision Correction After Surgery or Accident in Section 1: Covered Health Services.
2. Routine vision examinations, including refractive examinations to determine the need for vision correction.
3. Implantable lenses used only to correct 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:
   - For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
   - For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied 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 the Covered Person is enrolled under the Policy.

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

V. All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 9: Defined Terms. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:
   - Medically Necessary Health Care.
   - Described as a Covered Health Service in this Certificate under Section 1: Covered Health 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, vaccinations, immunizations or treatments that are otherwise covered under the Policy when:
   - Required solely for purposes of school, sports or camp, travel, career or employment, insurance, marriage or adoption.
   - Related to judicial or administrative proceedings or orders.
   - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in Section 1: Covered Health Services.
   - Required to obtain or maintain a license of any type.

3. Health 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 to Covered Persons who are civilians Injured or otherwise affected by war, any act of war, or terrorism in non-war zones.

4. Health services received after the date your coverage under the Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Policy ended. For more information about extension of benefits for disabled persons, see Section 4: When Coverage Ends under Extended Coverage for Total Disability.

5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy.

6. In the event a non-Network provider waives Copayments, Coinsurance and/or any deductible for a particular health service, no Benefits are provided for the health service for which the Copayments, Coinsurance and/or deductible are waived.

7. Charges in excess of Eligible Expenses or in excess of any specified limitation.

8. Long term (more than 30 days) storage, such as cryopreservation of tissue. This exclusion does not apply to blood and blood product storage related to blood transfusions.
10. Foreign language and sign language services.
11. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.

For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.
Section 3: When Coverage Begins

How to Enroll
Eligible Persons must complete an enrollment form. The Enrolling Group will give the necessary forms to you. The Enrolling Group will then submit the completed forms to us, along with any required Premium. We will not provide Benefits for health services that you receive before your effective date of coverage.

If You Are Hospitalized When Your Coverage Begins
If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, we will pay Benefits for Covered Health Services that you receive on or after your first day of coverage related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Policy. These Benefits are subject to any prior 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 is reasonably possible. For Benefit plans that have a Network Benefit level, Network Benefits are available only if you receive Covered Health Services from Network providers.

However, if your coverage under this Policy is replacing coverage from another policy between the Enrolling Group and a prior carrier, the following conditions apply. When a health care provider that has been providing health care services to you is not a Network provider, then we will pay Benefits for Covered Health Care Services in accordance with the paragraphs below in the same manner as if the provider had been terminated from the Provider Network arranged by us as of the date of policy replacement.

- We shall notify you of the termination of the provider's contract at least 60 days in advance of the termination. When circumstances related to the termination render such notice impossible, we shall provide you as much notice as is reasonably possible. Our notice will include instructions on obtaining an alternate provider and ensuring that there is no inappropriate disruption in your ongoing treatment.
- We will permit you to continue or be covered, with respect to the course of treatment with the provider, for a transitional period of at least 60 days from the date notice to you of the provider's termination except that if you are in the second trimester of pregnancy at the time of the provider's termination and the provider is treating you during the pregnancy, the transitional period will extend through the provision of postpartum care directly related to the pregnancy.
- We will make coverage of continued treatment by a provider in the item above conditional upon the provider's agreeing to the following terms and conditions:
  - The provider agrees to accept reimbursement from us at rates applicable prior to the start of the transitional period as payment in full and not to impose cost-sharing with respect to you in an amount that would exceed the cost-sharing that could have been imposed if the contract between us and the provider had not been terminated.
  - The provider agrees to adhere to our quality assurance standards and to provide us with the necessary medical information related to the care provided.
  - The provider agrees otherwise to adhere to our policies and procedures.

If You Are Eligible for Medicare
Your Benefits under the Policy may be reduced if you are eligible for Medicare but do not enroll in and maintain coverage under both Medicare Part A and Part B.

Your Benefits under the Policy may also be reduced if you are enrolled in a Medicare Advantage (Medicare Part C) plan but fail to follow the rules of that plan. Please see Medicare Eligibility in Section 8: General Legal Provisions for more information about how Medicare may affect your Benefits.
Who is Eligible for Coverage
The Enrolling Group determines who is eligible to enroll under the Policy and who qualifies as a Dependent.

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

Eligible Persons must reside within the United States.
If both spouses are Eligible Persons of the Enrolling 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 actually 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 to Enroll and When Coverage Begins
Except as described below, Eligible Persons may not enroll themselves or their Dependents.

Initial Enrollment Period
When the Enrolling 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 identified in the Policy if we receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible to enroll.

Open Enrollment Period
The Enrolling Group determines 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 Enrolling Group if we receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible to enroll.

New Eligible Persons
Coverage for a new Eligible Person and his or her Dependents begins on the date agreed to by the Enrolling Group if we 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.
- Registering a Domestic Partner.

Coverage for the Dependent begins on the date of the event if we receive the completed enrollment form and any required Premium within 31 days of the event that makes the new Dependent eligible.

Please note that Coverage exists during the initial 31-day period for a newly born or newly placed or adopted child. Completed enrollment and payment of any required Premium is required to have such coverage continue beyond that 31-day period.

**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 was terminated 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.
- Registering a Domestic Partner.

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 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 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 include the Eligible Person and/or Dependent.
- An Eligible Person and/or Dependent incurs a claim that would exceed a lifetime limit on all benefits.
- 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 if we 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 immediately 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
We may discontinue this Benefit plan and/or all similar benefit plans at any time for the reasons explained in the Policy, as permitted by law.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date. Please note that this does not affect coverage that is extended under Extended Coverage for Total Disability below.

When your coverage ends, we will still pay claims for Covered Health Services that you received before the date on which your coverage ended. However, once your coverage ends, we will not pay claims for any health services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended). Please note that this does not affect coverage that is extended under Extended Coverage for Total Disability below.

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

Please note that for Covered Persons who are subject to the Extended Coverage for Total Disability provision later in this section, entitlement to Benefits ends as described in that section.

Events Ending 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 the event the entire Policy ends, the Enrolling Group is responsible for notifying you that your coverage has ended.

- **You Are No Longer Eligible**
  Your coverage ends on the last day of the calendar month in which you are no longer eligible to be a Subscriber or Enrolled Dependent. Please refer to Section 9: Defined Terms for complete definitions of the terms “Eligible Person,” “Subscriber,” “Dependent” and “Enrolled Dependent.”

- **We Receive Notice to End Coverage**
  Your coverage ends on the last day of the calendar month in which we receive written notice from the Enrolling Group instructing us to end your coverage, or the date requested in the notice, if later. The Enrolling Group is responsible for providing written notice to us to end your coverage.

- **Subscriber Retires or Is Pensioned**
  Your coverage ends on the last day of the calendar month in which the Subscriber is retired or receiving benefits under the Enrolling Group’s pension or retirement plan. The Enrolling Group is responsible for providing written notice to us to end your coverage.

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

Other Events Ending Your Coverage
When either of the following happens, we will provide at least 30 days advance written notice to the Subscriber that coverage will end on the date we identify in the notice:

- **Fraud or Intentional Misrepresentation of a Material Fact**
You committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include false information relating to another person's eligibility or status as a Dependent.

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, during the first two years the Policy is in effect, 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. After the first two years, we can only demand that you pay back these Benefits if the written application contained a fraudulent misstatement.

**Third-Party Notice of Cancellation**

If you suffer from cognitive impairment or functional incapacity, you have the right to designate a third party to receive prior notice of cancellation for nonpayment of premium.

You have the right to have your coverage reinstated if the ground for cancellation was for nonpayment of premium or other lapse or default on your part. Within 90 days after cancellation, you or your designee may request reinstatement on the basis that the loss of coverage was a result of cognitive impairment or functional incapacity. We may require medical proof, at your expense, of one of these conditions.

If your coverage is reinstated, we will request payment for any unpaid premiums. Within 15 days of the request, you or your designee must submit payment. If payment is not received, the policy may not be reinstated and claims incurred since the date of cancellation will not be eligible for coverage under the Policy.

If your coverage is not reinstated, we will notify you or your designee of your right to request a hearing before the Superintendent of the Bureau of Insurance.

**Rescission of Coverage**

A rescission of coverage is a cancellation or discontinuation of coverage that has a retroactive effect. We will not rescind coverage under the Policy once it is in effect except in the case of fraud or intentional misrepresentation of a material fact as outlined in this section.

**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 the limiting age if both of the following are true regarding the Enrolled Dependent child:

- Is not able to be self-supporting because of mental or physical handicap or disability.
- Depends mainly on the Subscriber for support.

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

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

We may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical examinations at our expense. However, 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.
Extended Coverage for Total Disability
Coverage for a Covered Person who is Totally Disabled on the date the entire Policy is terminated will not end automatically. We will temporarily extend the coverage, only for treatment of the condition causing the Total Disability. Benefits will be paid until the earlier of either of the following:

- The Total Disability ends.
- Six months from the date coverage would have ended when the entire Policy was terminated.

Continuation of Coverage
If your coverage ends under the Policy, you may be entitled 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 Enrolling Groups that are subject to the terms of COBRA. You can contact your plan administrator to determine if your Enrolling Group is subject to the provisions of COBRA.

If you selected 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 Enrolling 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 Enrolling Group or its plan administrator fails to perform its responsibilities under federal law. Examples of the responsibilities of the Enrolling 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
If coverage would ordinarily terminate due to one of the following qualifying events, then you are entitled to continue coverage. You are entitled to elect the same coverage that you had on the day before the qualifying event.

Qualifying events are:

- Termination is due to temporary lay-off.
- Termination is due to a permanent lay-off when the terminated employee is eligible for premium assistance under federal law providing premium assistance for laid-off employees.
- Termination is due to an injury or disease subject to workers' compensation coverage.

Notification Requirements and Election Period for Continuation Coverage under State Law
You must elect continuation coverage within 31 days of the date your coverage ends. You should obtain an election form from the Enrolling Group's plan administrator 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 under the Policy will end on the earliest of the following dates:

- One year from the date of your last day of work.
- The date coverage terminates under the Policy 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 the entire Policy ends.
• When the Workers’ Compensation Board determines that the injury or disease that entitles the employee to continued coverage under this section is not compensable under Title 39-A.
Section 5: How to File a Claim

If You Receive Covered Health Services from a Network Provider

We pay Network providers directly for your Covered Health Services. For Network Benefits, you are not responsible for any difference between the Eligible Expenses and the amount the provider bills. You are not responsible for "balance billing" by Network providers. If a Network provider bills you for any Covered Health Service, contact us. However, you are responsible for meeting any applicable deductible and for paying any required Copayments and Coinsurance to a Network provider at the time of service, or when you receive a bill from the provider.

If You Receive Covered Health Services from a Non-Network Provider

When you receive Covered Health Services from a non-Network provider, you are responsible for requesting payment from us although the provider may accept assignment of benefits. The claim must be filed in a format that contains all of the information we require, as described below.

You must submit a request for payment of Benefits within 90 days after the date of service. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Written notice of sickness or of injury must be provided to us within 30 days after the date when such sickness or injury occurred. Failure to give notice within such time will not invalidate or reduce any claim if it was not reasonably possible to give such notice and that notice was given as soon as was reasonably possible.

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 insurance 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.

Payment of Benefits

If a Subscriber provides written authorization to allow this, all or a portion of any Eligible Expenses due to a provider may be paid directly to the provider instead of being paid to the Subscriber. But we will not reimburse third parties that have purchased or been assigned benefits by Physicians or other providers. Benefits will be paid to you unless either of the following is true:

- The provider notifies us that your signature is on file, assigning benefits directly to that provider.
• You make a written request at the time you submit your claim.

We will either pay or dispute a claim within 30 days after proof of loss is received. A claim that is not paid or disputed within 30 days is overdue. If during the 30 days we notify you in writing that additional information is required to review the claim, the claim is not overdue until 30 days after we receive the additional required information. If payment is not made on an undisputed claim when due, the amount of the overdue claim or part of the claim will be paid with interest at a rate of 1.5% per month after the due date.
Section 6: Questions, Complaints and Appeals

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

What to Do if You Have a Question

Contact Customer Care at the telephone number shown on your ID card. Customer Care representatives are available to take your call during regular business hours, Monday through Friday.

What to Do if You Have a Complaint

Contact Customer Care at the telephone number shown on your ID card. Customer Care 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 Customer Care representative can provide you with the appropriate address.

If the Customer Care representative cannot resolve the issue to your satisfaction over the phone, he/she can help you prepare and submit a written complaint, in written format, as a Grievance to our Customer Care Department. We will notify you of our decision regarding your complaint within 30 days of receiving it.

Grievance Procedure

"Grievance" means a written complaint submitted by or on behalf of you regarding the:

- Availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;
- Claims payment, handling, or reimbursement for health care services; or
- Matters pertaining to the contractual relationship between a Covered Person and us.

Outlined below are the procedures you should take if you have a Grievance.

Note: If you need assistance in submitting the Grievance you may contact the Superintendent's Office at anytime. The address is:

State of Maine Bureau of Insurance
Superintendent's Office
34 State House Station
Augusta, Maine 04333-0034
Customer Complaint: 1-800-300-5000
Fax: 207-624-8599

First Level Grievance

If you have a Grievance concerning any matter, except an adverse utilization review determination, you, or your representative, may submit it to Customer Care. We will issue a written decision to you or to your representative within 20 business days after receiving a Grievance and all information necessary for our review of the Grievance. Additional time is permitted where we can establish the 20 day time frame cannot reasonably be met due to our inability to obtain necessary information from a person or entity not affiliated with or under contract with us. We will provide written notice of the delay to you. The notice will explain the reasons for the delay. In such instances, decisions must be issued within 20 days of our receipt of all necessary information.

If there is an adverse decision, the decision will contain:
• The names, titles and qualifying credentials of the person or persons participating in the first level grievance review process (the reviewers).
• A statement of the reviewers' understanding of the Covered Person's grievance and all pertinent facts.
• The reviewers' decision in clear terms and the basis for the decision.
• A reference to the evidence or documentation used as the basis for the decision.
• Notice of your right to contact the Superintendent's office.
• A description of the process to obtain a second level grievance review of a decision, the procedures and time frames governing a second level grievance review, and the second level grievance rights.

Utilization Review Procedures
We use the following utilization review procedures described below to review select health care services against clinical criteria to determine whether the proposed service is covered under your benefit plan, and to facilitate clinically appropriate, cost-effective management of your care.

• Pre-service review of selected elective inpatient admissions, surgical day care, and outpatient/ambulatory procedures to determine whether proposed services meet clinical criteria for coverage. Prospective utilization review determinations will be made within two working days of obtaining all necessary information. In the case of a determination to approve an admission, procedure or service, we will give notice to the requesting provider by telephone within 24 hours of the decision and will send a written or electronic confirmation of the telephone notification to you and the provider within two working days thereafter. In the case of a determination to deny or reduce benefits (“an adverse determination”), we will notify the provider rendering the service by telephone within 24 hours of the decision and will send a written or electronic confirmation of the telephone notification to you and the provider within one working day thereafter.

• Concurrent utilization review of authorized admissions to hospitals and extended care facilities, and skilled home health services. Concurrent review decisions will be made within one working day of obtaining all necessary information. In the case of a determination to approve additional services, we will notify the provider rendering the service by telephone within 24 hours of the decision and will send a written or electronic confirmation of the telephone notification to you and the provider within one working day thereafter. In the case of an adverse determination, we will notify the provider rendering the service by telephone within 24 hours of the decision and will send a written or electronic confirmation of the telephone notification to you and the provider within one working day thereafter.

• Active case management and discharge planning may also be provided upon the request of the treating physician or to assist you in coordinating care.

Retrospective utilization review may be conducted in situations where services are not subject to pre-service review against clinical criteria.

If you wish to determine the status or outcome of a clinical review decision you may call the Customer Care telephone number shown on your ID card.

In the event of an adverse determination involving either a prospective, concurrent or retrospective clinical review, your treating provider may discuss your case with the physician reviewer making the adverse determination or may seek reconsideration from us. The reconsideration will take place within one working day of the request. The reconsideration will be conducted between the provider rendering the service and the reviewer who made the adverse determination, or a clinical peer designated by the reviewer if the reviewer cannot be available within one working day. If the adverse determination is not reversed on reconsideration you, or your provider on your behalf, may appeal. Your appeal rights are described in the following sections. Your right to appeal does not depend on whether or not your provider sought reconsideration.
Standard Appeals of Adverse Utilization Review Determinations

If you disagree with an adverse utilization review determination or a rescission of coverage determination, you have the right to appeal that determination. You should follow the procedure contained in the adverse utilization review determination letter. 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 sufficiently in advance of the due date of the response to the adverse determination.

We will notify in writing both you and the attending or ordering provider of the decision within 20 working days following the request for an appeal. Additional time is permitted where we can establish the 20 day time frame cannot reasonably be met due to our inability to obtain necessary information from a person or entity not affiliated with or under contract with us. We will provide written notice of the delay to you and the attending or ordering provider. The notice will explain the reasons for the delay. In such instances, decisions must be issued within 20 days of our receipt of all necessary information. An adverse decision will contain:

- The names, titles and qualifying credentials of the person or persons evaluating the appeal;
- A statement of the reviewers’ understanding of the reason for your request for an appeal;
- The reviewers’ decision in clear terms and the clinical rationale in sufficient detail for you to respond further to our position;
- A reference to the evidence or documentation used as the basis for the decision, including the clinical review criteria used to make the determination. The decision will include instructions for requesting copies of any referenced evidence, documentation or clinical review criteria not previously provided to you. Where you had previously submitted a written request for the clinical review criteria relied upon by us in rendering the initial adverse determination, the decision will include copies of any additional clinical review criteria utilized in arriving at the decision.

Second Level Review

If you were not satisfied with the written decision concerning your Grievance, you may request a second level review.

For second level Grievances involving an adverse utilization review determination, we will appoint a second level Grievance review panel for each Grievance. A majority of the panel will be comprised of health care professionals who are clinical peers. In cases where there has been a denial of service, the reviewing health care professionals will not have a financial interest in the outcome of the review. A majority of the panel will also be comprised of persons who were not previously involved in the Grievance, however a person who was previously involved with the Grievance may be a member of the panel or appear before the panel to present information or answer questions. The panel must include at least one health care professional who is a clinical peer and was not previously involved with the grievance.

For second level review of all Grievances other than those concerning an adverse utilization review determination, we will appoint a second level Grievance review panel for each Grievance. A majority of the panel will be comprised of our employees or representatives who were not previously involved in the Grievance. However, our employee or representative who was previously involved with the Grievance may be a member of the panel or appear before the panel to present information or answer questions.

If you request the opportunity to appear in person before our authorized representatives, the procedures for conducting a second level panel review will include the following:

- The review panel will schedule and hold a review meeting within 45 working days of receiving a request from you for a second level review.
- The review meeting will be held during regular business hours at a location reasonably accessible to you. In cases where a face-to-face meeting is not practical for geographic reasons, we will offer you the opportunity to communicate with the review panel, at our expense, by conference call, video conferencing, or other appropriate technology.
You will be notified in writing at least 15 working days in advance of the review date. We will not unreasonably deny a request for postponement of the review made by you.

Upon your request, we will provide to you all relevant information that is not confidential or privileged.

You have the right to:

- Attend the second level review;
- Present your case to the review panel;
- Submit supporting material both before and at the review meeting;
- Ask questions of any of our representatives; and
- Be assisted or represented by a person of your choice.

If we have an attorney present to argue our case against you, we will notify you at least 15 working days in advance of the review, and will advise you of your right to obtain legal representation.

Your right to a fair review will not be made conditional on your appearance at the review.

The review panel will issue a written decision to you within 5 working days of completing the review meeting.

If you elect not to attend the review committee meeting in person or participate by telephone, you will be provided with a written response to your appeal within thirty (30) calendar days of your request for a second level appeal.

**Urgent Appeals that Require Immediate Action**

**Expedited Review**

The following statements apply if you have a dispute about a pending health service which, in the opinion of your Physician, requires special consideration as an urgent situation. (NOTE: Prescheduled treatments, therapies, surgeries, or other procedures are not considered urgent situations.)

- The above Grievance procedures do not apply; and
- Your complaint does not need to be submitted in writing; and
- We will notify you of our decision regarding coverage by the end of the next business day following the date your complaint is registered, if any decision has been made. If we require additional information from your Physician in order to make a decision, we will notify you of the decision by the end of the next business day following receipt of required medical information.

If you are in an urgent situation, we will also provide an expedited review. An urgent situation is generally considered one where following the time frame of the standard Grievance procedures would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function. We will provide an expedited review for all requests concerning an admission, availability of care, continued stay or health care service for a Covered Person who has received emergency services but has not been discharged from a facility. Adverse determinations made on a retrospective basis may only be appealed through the standard Grievance process. We will provide you, or the provider acting on your behalf, reasonable access to a peer who can perform an expedited review within one day of the request. We will then provide you, or the provider acting on your behalf, all necessary information, including our decision by telephone, facsimile or the most expeditious method available within 72 hours of the request. A written confirmation of the decision will follow within 2 business days of the definition.

If the expedited review is a concurrent review determination of Emergency Health Services - Outpatient or of an initially notified admission or course of treatment, the service shall be continued without liability to you until you have been notified of the determination.
If you are dissatisfied with our decision following an expedited review, you, or the provider acting on your behalf, can then request a second level review. In performing a second level review following an expedited review, we will adhere to time frames that are reasonable under the circumstances.

Independent External Review Program
You have the right to an independent external review of our adverse health care treatment decision made by or on behalf of us in accordance with the requirements described below in this section. Your failure to obtain authorization prior to receiving an otherwise Covered Health Service may not preclude you from exercising your rights under this section.

Request for External Review
You or your authorized representative shall make a written request for external review of an adverse health care treatment decision to the Maine Bureau of Insurance. Except as provided below for an "Expedited Request for External Review", you may not make a request for external review until you have exhausted all levels of our internal Grievance procedure. A request for external review must be made within 12 months of the date an enrollee has received a final adverse health care treatment decision under our internal grievance procedure. You are not required to pay any filing fee as a condition of processing a request for external review.

Expedited Request for External Review
You or your authorized representative is not required to exhaust all levels of our internal Grievance procedure before filing a request for external review if:

- We fail to make a decision on an internal Grievance within the time period required;
- We have otherwise failed to adhere to the requirements applicable to the Grievance pursuant to state or federal law;
- You applied for expedited external review at the same time as applying for expedited internal review;
- We and you mutually agree to bypass the internal Grievance procedure;
- Your life or health is in serious jeopardy; or
- You have died.

Independent External Review Decision and Timelines
An independent external review decision is binding on us. An external review decision will be made in accordance with the following requirements.

- In rendering an external review decision, the independent review organization contracted by the Maine Bureau of Insurance must give consideration to the appropriateness of the requested Covered Health Service based upon the following:
  - All relevant clinical information relating to your physical and mental condition, including any competing clinical information;
  - Any concerns expressed by you concerning your health status; and
  - All relevant clinical standards and guidelines, including, but not limited to, those standards and guidelines relied upon by us or our utilization review entity.
- An external review decision must be issued in writing and must be based on the evidence presented by us and you or your authorized representative. You may submit and obtain evidence relating to the adverse health care treatment decision under review, attend the external review, ask questions of any of our representatives present at the external review and use outside assistance during the review process at your own expense.
• Except as provided in the next paragraph, an external review decision must be rendered by an independent review organization within 30 days of receipt of a completed request for external review from the Maine Bureau of Insurance.

• An external review decision must be made as expeditiously as your medical condition requires but in no event more than 72 hours after receipt of a completed request for external review if the time frame for review required in the paragraph above would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function.

• We shall provide auxiliary telecommunication devices or qualified interpreter services by a person proficient in American Sign Language when requested by you if you are deaf or hard-of-hearing or printed materials in an accessible format, including Braille, large-print materials, computer diskette, audio cassette or a reader when requested by you when you are visually impaired to allow you to exercise your right to an external review under this section.
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 Coordination of Benefits Applies
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. 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. 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.

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

A. 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 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. 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 is a health care expense, including deductibles, coinsurance and copayments, 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 in accordance with a 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 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 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.

**Order of Benefit Determination Rules**

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.

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 as an employee,
member, policyholder, subscriber or retiree longer 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.

C. This Coverage Plan reduces its benefits as described below for Covered Persons who are eligible
for Medicare when Medicare would be the Primary Coverage Plan.

Medicare benefits are determined as if the full amount that would have been payable under
Medicare was actually paid under Medicare, even if:

- The person is entitled but not enrolled in Medicare. Medicare benefits are determined as if
  the person were covered under Medicare Parts A and B.
- The person is enrolled in a Medicare Advantage (Medicare Part C) plan and receives non-
  covered services because the person did not follow all rules of that plan. Medicare benefits
  are determined as if the services were covered under Medicare Parts A and B.
- The person receives services from a provider who has elected to opt-out of Medicare.
  Medicare benefits are determined as if the services were covered under Medicare Parts A
  and B and the provider had agreed to limit charges to the amount of charges allowed under
  Medicare rules.
- The services are provided in any facility that is not eligible for Medicare reimbursements, including a Veterans Administration facility, facility of the Uniformed Services, or other facility of the federal government. Medicare benefits are determined as if the services were provided by a facility that is eligible for reimbursement under Medicare.

- The person is enrolled under a plan with a Medicare Medical Savings Account. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.

**Important:** If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under this Coverage Plan), you should enroll for and maintain coverage under both Medicare Part A and Part B. If you don’t enroll and maintain that coverage, and if we are secondary to Medicare, we will pay Benefits under this Coverage Plan as if you were covered under both Medicare Part A and Part B. As a result, your out-of-pocket costs will be higher.

If you have not enrolled in Medicare, Benefits will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider if either of the following applies:
- You are eligible for, but not enrolled in, Medicare and this Coverage Plan is secondary to Medicare.
- You have enrolled in Medicare but choose to obtain services from a doctor that opts-out of the Medicare program.

When calculating this Coverage Plan's Benefits in these situations for administrative convenience, we may, in our sole discretion, treat the provider’s billed charges, rather than the Medicare approved amount or Medicare limiting charge, as the Allowable Expense for both this Coverage Plan and Medicare.

**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 to 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 may 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.

**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.
When Medicare is Secondary
If you have other health insurance which is determined to be primary to Medicare, then Benefits payable under This Plan will be based on Medicare's reduced benefits. In no event will the combined benefits paid under these coverages exceed the total Medicare Eligible Expense for the service or item.
Section 8: General Legal Provisions

Your Relationship with Us
In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how we interact with your Enrolling Group's Benefit plan and how it may affect you. We help finance or administer the Enrolling Group's Benefit plan 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 Enrolling Group's Benefit plan will cover or pay for the health care that you may receive. The plan pays for Covered Health Services, which are more fully described in this Certificate.
- The plan may not pay for all treatments you or your Physician may believe are necessary. If the plan does not pay, you will be responsible for the cost.

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.

Our Relationship with Providers and Enrolling Groups
The relationships between us and Network providers and Enrolling Groups are solely contractual relationships between independent contractors. Network providers and Enrolling Groups are not our agents or employees. Neither we nor any of our employees are agents or employees of Network providers or the Enrolling Groups.

We do not provide health care services or supplies, nor do we practice medicine. Instead, 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, but does not assure the quality of the services provided. They are not our employees nor do we have any other relationship with Network providers such as principal-agent or joint venture. We are not liable 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 Enrolling Group's Benefit plan. We are not responsible for fulfilling any duties or obligations of an employer with respect to the Enrolling Group's Benefit plan.

The Enrollment 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 the termination of the Policy.

When the Enrolling 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 Enrolling 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.

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

The relationship between you and the Enrolling 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 Enrolling Group, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Enrolling Group is responsible for giving notice to you.

If the premium rate in our agreement with the Enrolling Group changes, we will provide written notice to the Subscriber at least 60 days in advance of the effective date of the change.

**Statements by Enrolling Group or Subscriber**

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

**Incentives to Providers**

We pay Network providers through various types of contractual arrangements, some of which 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 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.

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 contact 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; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

**Incentives to You**

Sometimes we may offer coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is
yours alone but we recommend that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. Contact us if you have any questions.

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. Rebates are passed on to you in the form of lower premiums and are not directly taken into account in determining your deductible, copayments or coinsurance.

Interpretation of Benefits
We have the right 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 delegate this discretionary 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, in our discretion, offer Benefits for services that would otherwise not be Covered Health 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.

Administrative Services
We may arrange for various persons or entities to provide administrative services in regard to the Policy, 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. 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 reserve the right, without your approval, to change, interpret, modify, withdraw or add Benefits or terminate 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 hereby 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. All of the following conditions apply:

- Amendments to the Policy are effective 60 days after we send written notice to the Enrolling Group.
- Riders are effective on the date we specify.
- 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.
- Amendment and Rider language must have been filed with, and approved by, the Maine Bureau of Insurance prior to issuance.

However, in applying the provisions of this section, the following applies: In renewing the policy in accordance with this section, we may modify the coverage, terms and conditions of the policy consistent
Information and Records
We may use your individually identifiable health information to administer the Policy and pay claims, to identify procedures, products, or services that you may find valuable, and 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 your 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 any and all records concerning health care services which are necessary to implement and administer the terms of the Policy, for appropriate medical review or quality assessment, or as we are required to do 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 we recommend that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from 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 necessary. Our designees have the same rights to this information as we have.

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.

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

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

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

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Policy), you should enroll in and maintain coverage under both Medicare Part A and Part B. If you don't enroll and maintain that coverage, and if we are the secondary payer as described in Section 7: Coordination of Benefits, we will pay Benefits under the Policy as if you were covered under both Medicare Part A and Part B. As a result, you will be responsible for the costs that Medicare would have paid and you will incur a larger out-of-pocket cost.
If you are enrolled in a Medicare Advantage (Medicare Part C) plan on a primary basis (Medicare pays before Benefits under the Policy), you should follow all rules of that plan that require you to seek services from that plan's participating providers. When we are the secondary payer, we will pay any Benefits available to you under the Policy as if you had followed all rules of the Medicare Advantage plan. You will be responsible for any additional costs or reduced Benefits that result from your failure to follow these rules, and you will incur a larger out-of-pocket cost.

Subrogation and Reimbursement

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. Immediately upon paying or providing any Benefit, we shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type for the reasonable value of any services and Benefits we provided to you, from any or all of the following listed below.

In addition to any subrogation rights and in consideration of the coverage provided by this Certificate, we shall also have an independent right to be reimbursed by you for the reasonable value of any services and Benefits we provide to you, from any or all of the following listed below.

- Third parties, including any person alleged to have caused you to suffer injuries or damages.
- Your employer.
- 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 resulting from injuries or damages for which Benefits were provided.
- Any person or entity who is liable for payment to you on any equitable or legal liability theory for injuries or damages for which Benefits were provided.

These third parties and persons or entities are collectively referred to as "Third Parties."

You agree as follows:

- That you will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement, including:
  - 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.
- That no court costs or attorneys' fees may be deducted from our recovery without our express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and we are not required to participate in or pay court costs or attorneys' fees to the attorney hired by you to pursue your damage/personal injury claim.
- That 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, with such proceeds available for collection to include any and all amounts earmarked as non-economic damage settlement or judgment.
- That benefits paid by us may also be considered to be benefits advanced.
That you agree that if you receive any payment from any potentially responsible party as a result of an injury or illness, whether by settlement (either before or after any determination of liability), or judgment, you will serve as a constructive trustee over the funds, and failure to hold such funds in trust will be deemed as a breach of your duties hereunder.

That you or an authorized agent, such as your attorney, must hold any funds due and owing us, as stated herein, separately and alone, and failure to hold funds as such will be deemed as a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.

That we may set off from any future benefits otherwise provided by us the value of benefits paid or advanced under this section to the extent not recovered by us.

That you will not accept any settlement that does not fully compensate or reimburse us without our written approval, nor will you do anything to prejudice our rights under this provision.

That you will assign to us all rights of recovery against Third Parties, to the extent of the reasonable value of services and Benefits we provided, plus reasonable costs of collection.

That our rights will be considered as the first priority claim against Third Parties, including tortfeasors from whom you are seeking recovery, to be paid before any other of your claims are paid.

That we may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including filing suit in your name, which does not obligate us in any way to pay you part of any recovery we might obtain.

That we shall not be obligated in any way to pursue this right independently or on your behalf.

That in the case of your wrongful death, the provisions of this section will apply to your estate, the personal representative of your estate and your heirs or beneficiaries.

That 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 a Third Party. If a parent or guardian may bring a claim for damages arising out of a minor's Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

However, in applying the provisions of this section, the following applies:

- Your prior written approval is required.
- Payments are made only on a just and equitable basis, and not on the basis of a priority lien. A just and equitable basis shall mean that any factors that diminish the potential value of the Covered Person's claim shall likewise reduce the share in the claim for those claiming payment for services or reimbursement. Such factors shall include, but are not limited to:
  - Legal defenses. Questions of liability and comparative negligence or other legal defenses.
  - Exigencies of trial. Exigencies of trial that reduce a settlement or award in order to resolve the claim.
  - Limits of coverage. Limits on the amount of applicable insurance coverage that reduce the claim to an amount recoverable by the Covered Person.

**Refund of Overpayments**

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

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- 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, the Covered Person agrees to help us get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits for the Covered Person that are payable under the Policy. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

Limitation of Action

You cannot bring any legal action against us to recover reimbursement prior to the expiration of 60 days after proof of loss has been filed in accordance with the requirements of the Policy. No legal action may be brought at all unless brought within 2 years from the expiration of the time within which proof of loss is required by the Policy.

Continuity of Coverage Under Maine Law

Continuity of coverage is provided if:

• Within 90 days before the date the Covered Person was either (i) enrolled under this Policy, or (ii) would have been eligible to enroll except for a waiting period for coverage established by the Enrolling Group, provided the Covered Person enrolled when initially eligible to do so.

• Within 180 days before the date the Covered Person enrolled under the Policy (or would have been eligible except for a waiting period for coverage established by the Enrolling Group and did enroll when initially eligible), if all of the following conditions are met:
  ▪ Prior coverage was terminated due to unemployment;
  ▪ The Covered Person received unemployment compensation for the period of unemployment; and
  ▪ The Covered Person was employed when coverage commenced under this Policy.

Entire Policy

The Policy issued to the Enrolling Group, including this Certificate, the Schedule of Benefits, the Enrolling Group’s application and any Riders and/or Amendments, constitutes the entire Policy.
Section 9: Defined Terms

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

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

An Alternate Facility may also provide Mental Health Services or Substance Use Disorder Services on an outpatient or inpatient basis.

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

Annual Deductible - for Benefit plans that have an Annual Deductible, this is the amount of Eligible Expenses you must pay for Covered Health Services per year before we will begin paying for Benefits. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Refer to the Schedule of Benefits to determine whether or not your Benefit plan is subject to payment of an Annual Deductible and for details about how the Annual Deductible applies.

Autism Spectrum Disorders - a group of neurobiological disorders, as defined in the Diagnostic and Statistical Manual, that includes Autistic Disorder, Rett's Syndrome, Asperger's Disorder, Childhood Disintegrated Disorder and Pervasive Development Disorders Not Otherwise Specified (PDDNOS).

Benefits - your right to payment for Covered Health Services that are available under the Policy. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of the Policy, including this Certificate, the Schedule of Benefits and any attached Riders and/or Amendments.

Biologically-based Mental Illness - any of the following biologically based mental illnesses as defined in the Diagnostic and Statistical Manual, except for those that are designated as “V” codes by the Diagnostic and Statistical Manual: psychotic disorders, including schizophrenia; dissociative disorders; mood disorders; anxiety disorders; personality disorders; paraphilias; attention deficit and disruptive behavior disorders; pervasive developmental disorders; tic disorders; eating disorders, including bulimia and anorexia; and substance use disorders.

Coinsurance - the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health 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.

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

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

- The applicable Copayment.
- The Eligible Expense.

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

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

- Medically Necessary Health Care.
• Described as a Covered Health Service in this Certificate under Section 1: Covered Health Services and in the Schedule of Benefits.

• Not otherwise excluded in this Certificate under Section 2: Exclusions and Limitations.

Covered Person - either the Subscriber or an Enrolled Dependent, but this term applies only while the person is enrolled under the Policy. References to "you" and "your" throughout this Certificate are references to a Covered Person.

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

Dependent - the Subscriber's legal spouse or a child of the Subscriber or the Subscriber's spouse. All references to the spouse of a Subscriber shall include a Domestic Partner. The term child includes any of the following:
• 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.

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

The definition of Dependent is subject to the following conditions and limitations:
• A Dependent includes any child listed above under 26 years of age.
• A Dependent includes an unmarried dependent child age 26 or older who is or becomes disabled and dependent upon the Subscriber.

A child who meets the requirements set forth above ceases to be eligible as a Dependent on the last day of the year following the date the child reaches age 26.

The Subscriber must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy these conditions.

A Dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order. The Enrolling Group is responsible for determining if an order meets the criteria of a Qualified Medical Child Support Order.

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 Facility - a facility that has entered into an agreement with us, or with an organization contracting on our behalf, to render Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within your geographic area. The fact that a Hospital is a Network Hospital does not mean that it is a Designated Facility.

Designated Network Benefits - for Benefit plans that have a Designated Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by a Physician or other
provider that we have identified as Designated Network providers. Refer to the Schedule of Benefits to determine whether or not your Benefit plan offers Designated Network Benefits and for details about how Designated Network Benefits apply.

**Designated Physician** - a Physician that we’ve identified through our designation programs as a Designated provider. A Designated Physician may or may not be located within your geographic area. The fact that a Physician is a Network Physician does not mean that he or she is a Designated Physician.

**Domestic Partner** – a partner with whom the Subscriber has established a Domestic Partnership and who:

- Is a mentally competent adult as is the Subscriber;
- Has lived in the same primary residence as the Subscriber for at least 12 months;
- Is not legally married to or legally separated from another individual;
- Is the sole partner of the Subscriber and expects to remain so; and
- Is jointly responsible with the Subscriber for each other’s common welfare as evidenced by joint living arrangements, joint financial arrangements or joint ownership or real or personal property.

**Domestic Partnership** - a relationship between a Subscriber and a Domestic Partner. All of the following requirements apply to both persons:

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

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

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

**Eligible Expenses** - for Covered Health Services, incurred while the Policy is in effect, Eligible Expenses are determined by us as stated below and as detailed in the Schedule of Benefits.

Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines. We develop our reimbursement policy guidelines, in our discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

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

Eligible Person - an employee of the Enrolling Group or other person whose connection with the Enrolling Group meets the eligibility requirements specified in both the application and the Policy. An Eligible Person must reside within the United States.

Emergency - a medical condition, physical or mental, manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in:

• Placing the health, physical or mental, of the individual (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; or

With respect to a pregnant woman who is having contractions:

• That there is inadequate time to effect a safe transfer to another hospital before delivery; or

• That transfer may pose a threat to the health or safety of the woman or unborn child.

Emergency Health Services - health care services and supplies necessary for the treatment of an Emergency. It means those health care services that are provided in an emergency facility or setting after the onset of an illness or medical condition that manifests itself by symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected by the prudent layperson, who possesses an average knowledge of health and medicine, to result in:

• Placing the Covered Person's physical and/or mental health in serious jeopardy;

• Serious impairment to bodily functions; or

• Serious dysfunction of any bodily organ or part.

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

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

Experimental or Investigational Service(s) - medical, surgical, diagnostic, psychiatric, mental health, substance use 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:

• Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the standard reference compendia American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.

• Subject to review and approval by any institutional review board for the proposed use. (Devices which are FDA approved under the Humanitarian Use Device exemption are not considered to be Experimental or Investigational.)

• The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exceptions:

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

• If you are not a participant in a qualifying clinical trial, as described under Clinical Trials in Section 1: Covered Health Services, and have a Sickness or condition that is likely to cause death within one year of the request for treatment we may, in our discretion, consider an otherwise
Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

**Generally Accepted Standards of Medical Practice** - 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 reserve the right to consult expert opinion in determining whether health care services are Medically Necessary Health Care. 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 within our sole discretion.

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 on www.myuhc.com or by calling Customer Care at the telephone number on your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.

**Genetic Testing** - examination of blood or other tissue for chromosomal and DNA abnormalities and alterations, or other expressions of gene abnormalities that may indicate an increased risk for developing a specific disease or disorder.

**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 primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. 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 primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution.

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

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

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

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

**Intensive Outpatient Treatment** - a structured outpatient mental health or substance use disorder treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

**Intermittent Care** - skilled nursing care that is provided or needed 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 exceptional circumstances when the need for additional care is finite and predictable.

**Manipulative Treatment** - the therapeutic application of chiropractic and/or osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

**Medically Necessary Health Care** - health care services or products provided to a Covered Person for the purpose of preventing, diagnosing or treating an illness, injury or disease or the symptoms of an illness, injury or disease in a manner that is:

- Consistent with generally accepted standards of medical practice;
- Clinically appropriate in terms of type, frequency, extent, site and duration;
- Demonstrated through scientific evidence to be effective in improving health outcomes;
- Representative of "best practices" in the medical profession; and
- Not primarily for the convenience of the Covered Person or physician or other health care practitioner.

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

**Mental Health Services** - Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

**Mental Health/Substance Use Disorder Designee** - the organization or individual, designated by us, that provides or arranges Mental Health Services and Substance Use Disorder Services for which Benefits are available under the Policy.

**Mental Illness** - those mental health or psychiatric diagnostic categories that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded under the Policy.

**Mobility Device** - A manual wheelchair, electric wheelchair, transfer chair or scooter.

**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; however, this does not include those providers who have agreed to discount their charges for Covered Health Services by way of their participation in the Shared Savings Program. 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 Services, but not all Covered Health 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 Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

**Network Benefits** - for Benefit plans that have a Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Network Benefits and for details about how Network Benefits apply.

**Non-Network Benefits** - for Benefit plans that have a Non-Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Non-Network Benefits and for details about how Non-Network Benefits apply.
Open Enrollment Period - a period of time that follows the Initial Enrollment Period during which Eligible Persons may enroll themselves and Dependents under the Policy. The Enrolling Group determines the period of time that is the Open Enrollment Period.

Out-of-Pocket Maximum - for Benefit plans that have an Out-of-Pocket Maximum, this is the maximum amount you pay every year. Refer to the Schedule of Benefits to determine whether or not your Benefit plan is subject to an Out-of-Pocket Maximum and for details about how the Out-of-Pocket Maximum applies.

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

Pharmaceutical Product(s) - U.S. Food and Drug Administration (FDA)-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under the Policy.

Pharmaceutical Product List - a list that categorizes into tiers medications, products or devices that have been approved by the U.S. Food and Drug Administration (FDA). This list is subject to our periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Pharmaceutical Product has been assigned through the Internet at www.myuhc.com or by calling Customer Care at the telephone number on your ID card.

Pharmaceutical Product List Management Committee - the committee that we designate for, among other responsibilities, classifying Pharmaceutical Products into specific tiers.

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

Please Note: Any dentist, psychologist, chiropractor, certified nurse practitioner, certified nurse midwife, clinical social worker, certified social worker, mental health services counseling professional, certified nurse clinical specialist in psychiatric and mental health nursing, registered nurse first assistant, podiatrist, optometrist, ophthalmologist, acupuncturist, independent practice dental hygienist, licensed clinical professional counselor, marriage and family counselor, pastoral counselor (except when providing services to a member of his or her church or congregation in the course of his or her duties as a pastor, minister or staff person) 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 Enrolling Group that includes all of the following:

- The Group Policy.
- This Certificate.
- The Schedule of Benefits.
- The Enrolling Group's application.
- Riders.
- Amendments.

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

Policy Charge - the sum of the Premiums for all Subscribers and Enrolled Dependents enrolled under the Policy.

Pregnancy - includes all of the following:

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

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

**Primary Physician** - a Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine. For Mental Health Services and Substance Use Disorder Services, any licensed clinician is considered on the same basis as a Primary Physician for the provision of all services other than psychological testing.

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

• No skilled services are identified.
• Skilled nursing resources are available in the facility.
• The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.
• The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.

**Residential Treatment Facility** - a facility which provides a program of effective Mental Health Services or Substance Use Disorder Services treatment and which meets all of the following requirements:

• It is established and operated in accordance with applicable state law for residential treatment programs.
• It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance Use Disorder Designee.
• It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
• It provides at least the following basic services in a 24-hour per day, structured milieu:
  - 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 Services not described in this Certificate. Covered Health Services provided by a Rider may be subject to payment of additional Premiums. (Note that Benefits for Outpatient Prescription Drugs, Pediatric Vision Care Services and Pediatric Dental Services, while presented in Rider format, are not subject to payment of additional Premiums and are included in the overall Premium for Benefits under the Policy. 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.

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

**Shared Savings Program** - the Shared Savings Program provides access to discounts from the provider’s charges when services are rendered by those non-Network providers that participate in that program. We will use the Shared Savings Program to pay claims when doing so will lower Eligible Expenses. We do not credential the Shared Savings Program providers and the Shared Savings Program
providers are not Network providers. Accordingly, in Benefit plans that have both Network and Non-Network levels of Benefits, Benefits for Covered Health Services provided by Shared Savings Program providers will be paid at the Non-Network Benefit level (except in situations when Benefits for Covered Health Services provided by non-Network providers are payable at Network Benefit levels, as in the case of Emergency Health Services). When we use the Shared Savings Program to pay a claim, patient responsibility is limited to Coinsurance calculated on the contracted rate paid to the provider, in addition to any required deductible.

**Sickness** - physical illness, disease or Pregnancy. The term Sickness as used in this Certificate does not include Mental Illness or substance use disorders, regardless of the cause or origin of the Mental Illness or substance use disorder.

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

**Specialist Physician** - 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. For Mental Health Services and Substance Use Disorder Services, any licensed clinician is considered on the same basis as a Specialist Physician. For Mental Health Services and Substance Use Disorder Services, a licensed clinician who provides psychological testing is considered on the same basis as a Specialist Physician.

**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 Enrolling Group.

**Substance Use Disorder Services** - Covered Health Services for the diagnosis and treatment of alcoholism and substance use disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

**Telemedicine** - the use of interactive audio, video or other electronic media for the purpose of diagnosis, consultation or treatment. “Telemedicine” does not include the use of audio-only telephone, facsimile machine, e-mail or the storage of images for future consultation.

**Therapeutic, Adjustive, and Manipulative Services** - detection or correction (by manual or mechanical means) of subluxation(s) in the body to remove nerve interference or its effects. The interference must be the result of, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

**Total Disability or Totally Disabled** - a Subscriber's inability to perform all of the substantial and material duties of his or her regular employment or occupation; and a Dependent's inability to perform the normal activities of a person of like age and sex.

**Transitional Care** - Mental Health Services and Substance Use Disorder Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

- Supervised living arrangements which are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

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

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)

- Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

We have a process by which we compile and review clinical evidence with respect to certain health 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.

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, in our discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

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

You can choose to receive Network Benefits or Non-Network Benefits.

**Network Benefits** apply to Covered Health Services that are provided by a Network Physician or other Network provider. For facility services, these are Benefits for Covered Health Services that are provided at a Network facility under the direction of either a Network or non-Network Physician or other provider. Network Benefits include Physician services provided in a Network facility by a Network or a non-Network anesthesiologist, Emergency room Physician, consulting Physician, radiologist, or pathologist. Emergency Health Services are always paid as Network Benefits.

**Non-Network Benefits** apply to Covered Health Services that are provided by a non-Network Physician or other non-Network provider, or Covered Health Services that are provided at a non-Network facility.

Depending on the geographic area and the service you receive, you may have access through our Shared Savings Program to non-Network providers who have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from these providers, the Coinsurance will remain the same as it is when you receive Covered Health Services from non-Network providers who have not agreed to discount their charges; however, the total that you owe may be less when you receive Covered Health Services from Shared Savings Program providers than from other non-Network providers because the Eligible Expense may be a lesser amount.

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 Enrolling Group, this Schedule of Benefits will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Network Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior authorization is required are identified below and in the Schedule of Benefits table within each Covered Health Service category.

We recommend that you confirm with us that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact 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 fail to prior authorize as required. You can contact us by calling the telephone number for Customer Care on your ID card.

When you choose to receive certain Covered Health Services from non-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 a non-Network provider intends to
admit you to a Network facility or refers you to other 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.

To obtain prior authorization, call the telephone number for Customer Care 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.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in
the Schedule of Benefits table to determine how far in advance you must obtain prior authorization.

Covered Health Services Received From Network Providers Which Require Prior Authorization:

- Ambulance - non-emergent air and ground.
- Clinical trials.
- Congenital heart disease surgery.
- Dental anesthesia services.
- Dental services - accidental.
- Infant Formula.
- Medical Foods.
- Obesity surgery.
- Transplants.

Covered Health Services Received From Non-Network Providers Which Require Prior
Authorization:

- Ambulance - non-emergent air and ground.
- Breast pumps.
- Children's Early Intervention Services.
- Clinical trials.
- Congenital heart disease surgery.
- Dental anesthesia services.
- Dental services - accidental.
- Diabetes equipment - insulin pumps over $1,000.
- Durable Medical Equipment over $1,000 in cost (either retail purchase cost or cumulative retail
  rental cost of a single item).
- Genetic Testing, including BRCA Genetic Testing.
- Hearing aids that exceed $1,000 in retail purchase cost.
- Home health care.
- Hospice care - inpatient.
• Hospital inpatient care - all scheduled admissions and maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery.
• Infant formula.
• Lab, X-ray and diagnostics - sleep studies.
• Lab, X-ray and major diagnostics - CT, PET Scans, MRI, MRA, Nuclear Medicine and Capsule Endoscopy.
• Medical foods.
• Mental Health Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility), Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.
• Neurobiological disorders - Autism Spectrum Disorder services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility), Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; Applied Behavioral Analysis (ABA).
• Obesity surgery.
• Pain management.
• Pharmaceutical Products - IV infusions only.
• Certain Pharmaceutical Products. You may determine whether a particular Pharmaceutical Product requires authorization through the Internet at www.myuhc.com or by calling Customer Care at the telephone number on your ID card.
• Prosthetic devices over $1,000 in cost per device.
• Reconstructive procedures, including breast reconstruction surgery following mastectomy and breast reduction surgery.
• Rehabilitation Services – Outpatient Therapy.
• Skilled Nursing Facility and Inpatient Rehabilitation Facility services.
• Substance Use Disorder Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility), Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.
• Surgery - all outpatient surgeries.
• Temporomandibular joint services.
• Therapeutic, Adjustive and Manipulative Services.
• Therapeutics - all outpatient therapeutics.
• Transplants.
• Ventricular assist device implantation. You must obtain prior authorization as soon as the possibility of implantation arises except in cases of Emergency implantations of partial assist devices.

For all other services, when you choose to receive services from non-Network providers, we urge you to confirm with us that the services you plan to receive are Covered Health 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 Service, and therefore are excluded. In other instances, the same
procedure may meet the definition of Covered Health 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 actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health 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 implement 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 Services.

**Benefits**

Annual Deductibles are calculated on either a calendar or Policy year basis depending upon the Enrolling Group’s selection.

Out-of-Pocket Maximums are calculated on either a calendar or Policy year basis depending upon the Enrolling Group’s selection.

When Benefit limits apply, the limit stated refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

Benefit limits are calculated on either a calendar or Policy year basis depending upon the Enrolling Group’s selection unless otherwise specifically stated.
### Payment Term And Description

<table>
<thead>
<tr>
<th>Annual Deductible</th>
<th>Amounts</th>
</tr>
</thead>
<tbody>
<tr>
<td>The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits.</td>
<td><strong>Network</strong>&lt;br&gt;For single coverage, the Annual Deductible is $2,000 per Covered Person.&lt;br&gt;If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is $4,000. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.</td>
</tr>
<tr>
<td>Amounts paid toward the Annual Deductible for Covered Health 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.</td>
<td><strong>Non-Network</strong>&lt;br&gt;For single coverage, the Annual Deductible is $4,000 per Covered Person.&lt;br&gt;If more than one person in a family is covered under the Policy, the single coverage Annual Deductible stated above does not apply. For family coverage, the family Annual Deductible is $8,000. No one in the family is eligible to receive Benefits until the family Annual Deductible is satisfied.</td>
</tr>
<tr>
<td>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.</td>
<td><strong>Network</strong>&lt;br&gt;For single coverage, the Out-of-Pocket Maximum is $6,250 per Covered Person.&lt;br&gt;If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is $12,500. The Out-of-Pocket Maximum includes the Annual Deductible</td>
</tr>
<tr>
<td>The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the Schedule of Benefits table.</td>
<td><strong>Non-Network</strong>&lt;br&gt;For single coverage, the Out-of-Pocket Maximum is $8,000 per Covered Person.&lt;br&gt;If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is $16,000. No one in the family is eligible to receive Benefits until the family Out-of-Pocket Maximum is satisfied.</td>
</tr>
</tbody>
</table>

### Out-of-Pocket Maximum

<p>| The maximum you pay per year for the Annual Deductible or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. | <strong>Network</strong>&lt;br&gt;For single coverage, the Out-of-Pocket Maximum is $6,250 per Covered Person.&lt;br&gt;If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is $12,500. The Out-of-Pocket Maximum includes the Annual Deductible |
| Copayments and Coinsurance for some Covered Health Services will never apply to the Out-of-Pocket Maximum and those Benefits will never be payable at 100% even when the Out-of-Pocket Maximum is reached. Details about the way in which Eligible Expenses are determined appear at the end of the Schedule of Benefits table. | <strong>Non-Network</strong>&lt;br&gt;For single coverage, the Out-of-Pocket Maximum is $8,000 per Covered Person.&lt;br&gt;If more than one person in a family is covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is $16,000. No one in the family is eligible to receive Benefits until the family Out-of-Pocket Maximum is satisfied. |
| The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you will still be required to pay the following: |  |
| • Any charges for non-Covered Health Services. |  |
| • The amount Benefits are reduced if you do not obtain prior authorization as required. |  |
| • Charges that exceed Eligible Expenses. |  |</p>
<table>
<thead>
<tr>
<th>Payment Term And Description</th>
<th>Amounts</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Copayments or Coinsurance for any Covered Health Service identified in the Schedule of Benefits table that does not apply to the Out-of-Pocket Maximum.</td>
<td>covered under the Policy, the single coverage Out-of-Pocket Maximum stated above does not apply. For family coverage, the family Out-of-Pocket Maximum is $16,000. The Out-of-Pocket Maximum includes the Annual Deductible</td>
</tr>
<tr>
<td>• Copayments or Coinsurance for Covered Health Services provided under the <em>Outpatient Prescription Drug Rider.</em></td>
<td></td>
</tr>
</tbody>
</table>

**Copayment**

Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service.

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

- The applicable Copayment.
- The Eligible Expense.

Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

**Coinsurance**

Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services.

Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.
When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

<table>
<thead>
<tr>
<th>Covered Health Service</th>
<th>Benefit (The Amount We Pay, based on Eligible Expenses)</th>
<th>Apply to the Out-of-Pocket Maximum?</th>
<th>Must You Meet Annual Deductible?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Ambulance Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Prior Authorization Requirement</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses up to a maximum reduction of $500.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Emergency Ambulance</strong></td>
<td><strong>Network</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ground Ambulance:</td>
<td>80%</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Air Ambulance:</td>
<td>80%</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Non-Network</strong></td>
<td>Same as Network</td>
<td>Same as Network</td>
<td>Same as Network</td>
</tr>
<tr>
<td><strong>Non-Emergency Ambulance</strong></td>
<td><strong>Network</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ground or air ambulance, as we determine appropriate.</td>
<td>Ground Ambulance:</td>
<td>80%</td>
<td>Yes</td>
</tr>
<tr>
<td>Air Ambulance:</td>
<td>80%</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Non-Network</strong></td>
<td>Same as Network</td>
<td>Same as Network</td>
<td>Same as Network</td>
</tr>
<tr>
<td><strong>2. Autism Spectrum Disorder Treatment for Children Age Ten and Under</strong></td>
<td><strong>Network</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>80%</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Non-Network</strong></td>
<td>60%</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>3. Children's Early Intervention Services</strong></td>
<td><strong>Prior Authorization Requirement</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SBN.ACA15.CHP.MY-7.SB.I.11.ME [7]
When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

<table>
<thead>
<tr>
<th>Covered Health Service</th>
<th>Benefit (The Amount We Pay, based on Eligible Expenses)</th>
<th>Apply to the Out-of-Pocket Maximum?</th>
<th>Must You Meet Annual Deductible?</th>
</tr>
</thead>
<tbody>
<tr>
<td>For Non-Network Benefits you must obtain prior authorization five business days before receiving early intervention services or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses up to a maximum reduction of $500.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Network**
Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.

**Non-Network**
Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.

### 4. Clinical Trials

**Prior Authorization Requirement**
You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses up to a maximum reduction of $500.

Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this Schedule of Benefits.

Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Non-Network Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)

**Network**
Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.

**Non-Network**
Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.

### 5. Congenital Heart Disease Surgeries
When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

<table>
<thead>
<tr>
<th>Covered Health Service</th>
<th>Benefit (The Amount We Pay, based on Eligible Expenses)</th>
<th>Apply to the Out-of-Pocket Maximum?</th>
<th>Must You Meet Annual Deductible?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Network 80%</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Non-Network 60%</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Prior Authorization Requirement**

For Non-Network Benefits you must obtain prior authorization as soon as the possibility of a congenital heart disease (CHD) surgery arises. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses up to a maximum reduction of $500.

Network and Non-Network Benefits under this section include only the inpatient facility charges for the congenital heart disease (CHD) surgery. Depending upon where the Covered Health 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 Service category in this Schedule of Benefits.

**6. Dental Anesthesia Services**

**Prior Authorization Requirement**

For Network and Non-Network Benefits you must obtain prior authorization five business days before receiving services or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses up to a maximum reduction of $500.

Network

Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.

Non-Network

Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.

**7. Dental Services - Accident Only**
When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

<table>
<thead>
<tr>
<th>Covered Health Service</th>
<th>Benefit (The Amount We Pay, based on Eligible Expenses)</th>
<th>Apply to the Out-of-Pocket Maximum?</th>
<th>Must You Meet Annual Deductible?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Prior Authorization Requirement

For Network and Non-Network Benefits you must obtain prior authorization five business days before follow-up (post-Emergency) treatment begins. (You do not have to obtain prior authorization before the initial Emergency treatment.) If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses up to a maximum reduction of $500.

<table>
<thead>
<tr>
<th>Network</th>
<th>80%</th>
<th>Yes</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Network</td>
<td>Same as Network</td>
<td>Same as Network</td>
<td>Same as Network</td>
</tr>
</tbody>
</table>

8. Diabetes Services

Prior Authorization Requirement

For Non-Network Benefits you must obtain prior authorization before obtaining any Durable Medical Equipment for the management and treatment of diabetes that exceeds $1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses up to a maximum reduction of $500.

Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care

<table>
<thead>
<tr>
<th>Network</th>
<th>Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Network</td>
<td>Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.</td>
</tr>
</tbody>
</table>

Diabetes Self-Management Items and Medications

Benefits for diabetes equipment that meets the definition of Durable Medical Equipment are subject to the limit stated under Durable Medical Equipment.

<table>
<thead>
<tr>
<th>Network</th>
<th>Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under Durable Medical Equipment and in the Outpatient Prescription Drug Rider.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Network</td>
<td>Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under Durable Medical Equipment and in the Outpatient Prescription Drug Rider.</td>
</tr>
</tbody>
</table>
When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

<table>
<thead>
<tr>
<th>Covered Health Service</th>
<th>Benefit (The Amount We Pay, based on Eligible Expenses)</th>
<th>Apply to the Out-of-Pocket Maximum?</th>
<th>Must You Meet Annual Deductible?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Prescription Drug Rider.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

9. Durable Medical Equipment

Prior Authorization Requirement

For Non-Network Benefits you must obtain prior authorization before obtaining any Durable Medical Equipment that exceeds $1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses up to a maximum reduction of $500.

To receive Network Benefits, you must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.

<table>
<thead>
<tr>
<th>Covered Health Service</th>
<th>Benefit (The Amount We Pay, based on Eligible Expenses)</th>
<th>Apply to the Out-of-Pocket Maximum?</th>
<th>Must You Meet Annual Deductible?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Network 80%</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Non-Network 60%</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

10. Emergency Health Services - Outpatient

Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health 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 non-Network Hospital after the date we decide a transfer is medically appropriate, Benefits will not be provided. Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service.

Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under Eligible Expenses in this Schedule of Benefits. As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense.

<table>
<thead>
<tr>
<th>Covered Health Service</th>
<th>Benefit (The Amount We Pay, based on Eligible Expenses)</th>
<th>Apply to the Out-of-Pocket Maximum?</th>
<th>Must You Meet Annual Deductible?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Network 80%</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>
When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

<table>
<thead>
<tr>
<th>Covered Health Service</th>
<th>Benefit (The Amount We Pay, based on Eligible Expenses)</th>
<th>Apply to the Out-of-Pocket Maximum?</th>
<th>Must You Meet Annual Deductible?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>for reimbursement.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Non-Network</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Same as Network</td>
<td>Same as Network</td>
<td>Same as Network</td>
</tr>
<tr>
<td>11. Family Planning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Network</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits. Contraceptives are covered under the Outpatient Prescription Drug Schedule of Benefits.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Non-Network</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits. Contraceptives are covered under the Outpatient Prescription Drug Schedule of Benefits.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Hearing Aids</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Prior Authorization Requirement</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>For Non-Network Benefits you must obtain prior authorization before obtaining a hearing aid that exceeds $1,000 in retail purchase cost. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses up to a maximum reduction of $500.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Enrolled Dependent Children 18 years of age or under:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Benefits are limited to a single purchase (including repair/replacement) per hearing impaired ear every 3 years.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Adults 19 years of age or older:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Limited to $2,500 in Eligible Expenses per year. Benefits are further limited to a single purchase (including repair/replacement) every three years.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Network</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>80%</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td><strong>Non-Network</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>60%</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

<table>
<thead>
<tr>
<th>Covered Health Service</th>
<th>Benefit (The Amount We Pay, based on Eligible Expenses)</th>
<th>Apply to the Out-of-Pocket Maximum?</th>
<th>Must You Meet Annual Deductible?</th>
</tr>
</thead>
</table>

**13. Home Health Care**

**Prior Authorization Requirement**
For Non-Network Benefits you must obtain prior authorization five business days before receiving services or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses up to a maximum reduction of $500.

<table>
<thead>
<tr>
<th>Network 80% Non-Network 60%</th>
<th>Apply to the Out-of-Pocket Maximum?</th>
<th>Must You Meet Annual Deductible?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**14. Hospice Care**

**Prior Authorization Requirement**
For Non-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 fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses up to a maximum reduction of $500.

In addition, for Non-Network Benefits, you must contact us within 24 hours of admission for an Inpatient Stay in a hospice facility.

<table>
<thead>
<tr>
<th>Network 80% Non-Network 60%</th>
<th>Apply to the Out-of-Pocket Maximum?</th>
<th>Must You Meet Annual Deductible?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**15. Hospital - Inpatient Stay**

**Prior Authorization Requirement**
For Non-Network Benefits for a non-emergency 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 fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses up to a maximum reduction of $500.

In addition, for Non-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).

<table>
<thead>
<tr>
<th>Network 80% Non-Network 60%</th>
<th>Apply to the Out-of-Pocket Maximum?</th>
<th>Must You Meet Annual Deductible?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

<table>
<thead>
<tr>
<th>Covered Health Service</th>
<th>Benefit (The Amount We Pay, based on Eligible Expenses)</th>
<th>Apply to the Out-of-Pocket Maximum?</th>
<th>Must You Meet Annual Deductible?</th>
</tr>
</thead>
<tbody>
<tr>
<td>16. Infant Formula</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Prior Authorization Requirement
For Network and Non-Network Benefits you must obtain prior authorization five business days before receiving services or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses up to a maximum reduction of $500.

<table>
<thead>
<tr>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>80%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>60%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

17. Lab, X-Ray and Diagnostics - Outpatient

Prior Authorization Requirement
For Non-Network Benefits for sleep studies, you must obtain prior authorization five business days before scheduled services are received. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses up to a maximum reduction of $500.

Lab Testing - Outpatient:

- Human Leukocyte Antigen Testing
  - Network
    - 80%
    - 100% up to the first $150 in eligible expenses; then covered as stated in Lab Testing – Outpatient.
  - Non-Network
    - 60%

X-Ray and Other Diagnostic Testing - Outpatient:

<table>
<thead>
<tr>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>80%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>60%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

18. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization five business days before scheduled
When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

<table>
<thead>
<tr>
<th>Covered Health Service</th>
<th>Benefit (The Amount We Pay, based on Eligible Expenses)</th>
<th>Apply to the Out-of-Pocket Maximum?</th>
<th>Must You Meet Annual Deductible?</th>
</tr>
</thead>
<tbody>
<tr>
<td>services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses up to a maximum reduction of $500.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Network | 80% | Yes | Yes |
| Non-Network | 60% | Yes | Yes |

**19. Medical Foods**

**Prior Authorization Requirement**

For Network and Non-Network Benefits you must obtain prior authorization five business days before receiving services or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses up to a maximum reduction of $500.

| Network | 80% or as stated under the Outpatient Prescription Drug Rider. | Yes | Yes |
| Non-Network | 60% or as stated under the Outpatient Prescription Drug Rider. | Yes | Yes |

**20. Mental Health Services**

**Prior Authorization Requirement**

For Non-Network Benefits for a scheduled admission for Mental Health Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

In addition, for Non-Network Benefits you must obtain prior authorization before the following services are received. Services requiring prior authorization: Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.

If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses up to a maximum reduction of $500.

<table>
<thead>
<tr>
<th>Network</th>
<th>Inpatient</th>
<th></th>
</tr>
</thead>
</table>
When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

<table>
<thead>
<tr>
<th>Covered Health Service</th>
<th>Benefit (The Amount We Pay, based on Eligible Expenses)</th>
<th>Apply to the Out-of-Pocket Maximum?</th>
<th>Must You Meet Annual Deductible?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>80%</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Outpatient</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>80%</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Non-Network</td>
<td>Inpatient</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>60%</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Outpatient</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>60%</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

21. Neurobiological Disorders - Autism Spectrum Disorder Services

Prior Authorization Requirement

For Non-Network Benefits for a scheduled admission for Neurobiological Disorders - Autism Spectrum Disorder Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

In addition, for Non-Network Benefits you must obtain prior authorization before the following services are received. Services requiring prior authorization: Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; Applied Behavioral Analysis.

If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses up to a maximum reduction of $500.

<table>
<thead>
<tr>
<th></th>
<th>Network</th>
<th>Apply to the Out-of-Pocket Maximum?</th>
<th>Must You Meet Annual Deductible?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Inpatient</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>80%</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Outpatient</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>80%</td>
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<td>Yes</td>
</tr>
<tr>
<td>Non-Network</td>
<td>Inpatient</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>60%</td>
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<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Outpatient</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>60%</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

22. Obesity Surgery

Prior Authorization Requirement
When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

<table>
<thead>
<tr>
<th>Covered Health Service</th>
<th>Benefit (The Amount We Pay, based on Eligible Expenses)</th>
<th>Apply to the Out-of-Pocket Maximum?</th>
<th>Must You Meet Annual Deductible?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>You must obtain prior authorization six months prior to surgery or as soon as the possibility of obesity surgery arises. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses up to a maximum reduction of $500. In addition, for Non-Network Benefits you must contact us 24 hours before admission for an Inpatient Stay. <strong>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.</strong> For Network Benefits, obesity surgery must be received at a Designated Facility. Non-Network Benefits include services provided at a Network facility that is not a Designated Facility and services provided at a non-Network facility.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Network</strong> Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits. <strong>Non-Network</strong> Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 23. Ostomy Supplies

<table>
<thead>
<tr>
<th></th>
<th><strong>Network</strong></th>
<th><strong>Non-Network</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited to $2,500 per year.</td>
<td>80% Yes Yes</td>
<td>60% Yes Yes</td>
</tr>
</tbody>
</table>

### 24. Parenteral and Enteral Therapy

<table>
<thead>
<tr>
<th></th>
<th><strong>Network</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Network</strong></td>
<td>80% Yes Yes</td>
</tr>
</tbody>
</table>

### 25. Pharmaceutical Products - Outpatient

<table>
<thead>
<tr>
<th>Prior Authorization Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>For Non-Network Benefits you must obtain prior authorization five business days before certain Pharmaceutical Products are received, or for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses up to a maximum reduction of $500. You may determine whether a particular Pharmaceutical Product requires prior authorization through the Internet at <a href="http://www.myuhc.com">www.myuhc.com</a> or by calling Customer Care at the telephone number on your ID card.</td>
</tr>
</tbody>
</table>

SBN.ACA15.CHP.MY-7.SB.I.11.ME [17]
When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

<table>
<thead>
<tr>
<th>Covered Health Service</th>
<th>Benefit (The Amount We Pay, based on Eligible Expenses)</th>
<th>Apply to the Out-of-Pocket Maximum?</th>
<th>Must You Meet Annual Deductible?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Network 80%</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Non-Network 60%</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The following supply limits apply:
- As written by the provider, up to a consecutive 31-day supply of a Pharmaceutical Product, unless adjusted based on the manufacturer's packaging size, or based on supply limits.

When a Pharmaceutical Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.

26. Physician Fees for Surgical and Medical Services

Covered Health Services provided by a non-Network facility based Physician in a Network facility will be paid at the Network Benefits level, however Eligible Expenses will be determined as described below under Eligible Expenses in this Schedule of Benefits. As a result, you will be responsible to the non-Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.

Prior Authorization Requirement

For Non-Network Benefits you must obtain prior authorization as soon as is reasonably possible before Genetic Testing, including BRCA Genetic Testing, is performed. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses up to a maximum reduction of $500.

27. Physician's Office Services - Sickness and Injury

<table>
<thead>
<tr>
<th></th>
<th>Network 80%</th>
<th>Yes</th>
<th>Yes</th>
</tr>
</thead>
</table>
When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

<table>
<thead>
<tr>
<th>Covered Health Service</th>
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<th>Apply to the Out-of-Pocket Maximum?</th>
<th>Must You Meet Annual Deductible?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Non-Network</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>60%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**apply when the Covered Health Service is performed in a Physician's office:**
- Major diagnostic and nuclear medicine described under Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.
- Outpatient Pharmaceutical Products described under Pharmaceutical Products - Outpatient.
- Diagnostic and therapeutic scopic procedures described under Scopic Procedures - Outpatient Diagnostic and Therapeutic.
- Outpatient surgery procedures described under Surgery - Outpatient.
- Outpatient therapeutic procedures described under Therapeutic Treatments - Outpatient.

28. Pregnancy - Maternity Services

**Prior Authorization Requirement**

For Non-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 fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses up to a maximum reduction of $500.

It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.

**Network**

Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits 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. For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.
When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

<table>
<thead>
<tr>
<th>Covered Health Service</th>
<th>Benefit (The Amount We Pay, based on Eligible Expenses)</th>
<th>Apply to the Out-of-Pocket Maximum?</th>
<th>Must You Meet Annual Deductible?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Network</td>
<td>Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits 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.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

29. Preventive Care Services

For Non-Network Benefits, you must obtain prior authorization before obtaining a breast pump. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses up to a maximum reduction of $500.

<table>
<thead>
<tr>
<th>Physician office services</th>
<th>Network</th>
<th>Non-Network</th>
<th>Apply to the Out-of-Pocket Maximum?</th>
<th>Must You Meet Annual Deductible?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>100%</td>
<td>60%</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lab, X-ray or other preventive tests</th>
<th>Network</th>
<th>Non-Network</th>
<th>Apply to the Out-of-Pocket Maximum?</th>
<th>Must You Meet Annual Deductible?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>100%</td>
<td>60%</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Breast pumps</th>
<th>Network</th>
<th>Non-Network</th>
<th>Apply to the Out-of-Pocket Maximum?</th>
<th>Must You Meet Annual Deductible?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>100%</td>
<td>60%</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

30. Prosthetic Devices

Prior Authorization Requirement

For Non-Network Benefits you must obtain prior authorization before obtaining prosthetic devices that exceed $1,000 in cost per device. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses up to a maximum reduction of $500.

<table>
<thead>
<tr>
<th>Network</th>
<th>Non-Network</th>
<th>Apply to the Out-of-Pocket Maximum?</th>
<th>Must You Meet Annual Deductible?</th>
</tr>
</thead>
<tbody>
<tr>
<td>80%</td>
<td>60%</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

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<thead>
<tr>
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<th>Benefit (The Amount We Pay, based on Eligible Expenses)</th>
<th>Apply to the Out-of-Pocket Maximum?</th>
<th>Must You Meet Annual Deductible?</th>
</tr>
</thead>
</table>

### 31. Reconstructive Procedures

**Prior Authorization Requirement**

For Non-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 fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses up to a maximum reduction of $500.

In addition, for Non-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 (including Emergency admissions).

**Network**

Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.

**Non-Network**

Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.

### 32. Rehabilitation Services - Outpatient Therapy

**Prior Authorization Requirement**

For Non-Network Benefits you must obtain prior authorization five business days before receiving physical therapy, occupational therapy, speech therapy, massage therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy, and cognitive rehabilitation therapy or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses up to a maximum reduction of $500.

- **Limited per year as follows:**
  - 44 visits of physical therapy.
  - 44 visits of occupational therapy.
  - 44 visits of speech therapy.
  - 30 visits of post-cochlear implant aural therapy.
  - 20 visits of cognitive rehabilitation therapy.
  - 36 visits of cardiac rehabilitation therapy.
  - Unlimited visits of pulmonary

**Network**

- 80%

**Non-Network**

- 60%

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Yes</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Network</td>
<td></td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Non-Network</td>
<td></td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
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<table>
<thead>
<tr>
<th>Covered Health Service</th>
<th>Benefit (The Amount We Pay, based on Eligible Expenses)</th>
<th>Apply to the Out-of-Pocket Maximum?</th>
<th>Must You Meet Annual Deductible?</th>
</tr>
</thead>
<tbody>
<tr>
<td>therapy.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

33. Scopic Procedures - Outpatient Diagnostic and Therapeutic

Prior Authorization Requirement

For Non-Network Benefits 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 fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses up to a maximum reduction of $500.

<table>
<thead>
<tr>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

34. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Prior Authorization Requirement

For Non-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 fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses up to a maximum reduction of $500.

In addition, for Non-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).

Covered Health Services in a Skilled Nursing Facility are not subject to an annual limit.

Limited to 60 days per year in an Inpatient Rehabilitation Facility.

<table>
<thead>
<tr>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

35. Smoking Cessation

Limited to:
- 2 Physician Office Visits per calendar year.
- Up to $35 per Smoking Cessation Program.

Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.

<table>
<thead>
<tr>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
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<th>Covered Health Service</th>
<th>Benefit (The Amount We Pay, based on Eligible Expenses)</th>
<th>Apply to the Out-of-Pocket Maximum?</th>
<th>Must You Meet Annual Deductible?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 36. Substance Use Disorder Services

**Prior Authorization Requirement**

For Non-Network Benefits for a scheduled admission for Substance Use Disorder Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

In addition, for Non-Network Benefits you must obtain prior authorization before the following services are received. Services requiring prior authorization: Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.

If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses up to a maximum reduction of $500.

<table>
<thead>
<tr>
<th></th>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>80%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

### 37. Surgery - Outpatient

**Prior Authorization Requirement**

For Non-Network Benefits for all outpatient surgeries 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 fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses up to a maximum reduction of $500.

<table>
<thead>
<tr>
<th></th>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>80%</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
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<table>
<thead>
<tr>
<th>Covered Health Service</th>
<th>Benefit (The Amount We Pay, based on Eligible Expenses)</th>
<th>Apply to the Out-of-Pocket Maximum?</th>
<th>Must You Meet Annual Deductible?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>60%</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

38. Therapeutic, Adjustive and Manipulative Services

Prior Authorization Requirement

For Non-Network Benefits you must obtain prior authorization five business days before receiving Therapeutic, Adjustive and Manipulative Services or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses up to a maximum reduction of $500.

Any combination of Network and Non-Network Benefits for therapeutic, adjustive and manipulative services is limited to 40 visits per year.

<table>
<thead>
<tr>
<th>Network</th>
<th>Non-Network</th>
<th>Yes</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>80%</td>
<td>60%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

39. Therapeutic Treatments - Outpatient

Prior Authorization Requirement

For Non-Network Benefits you must obtain prior authorization for all 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. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses up to a maximum reduction of $500.

<table>
<thead>
<tr>
<th>Network</th>
<th>Non-Network</th>
<th>Yes</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>80%</td>
<td>60%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

40. Transplantation Services

Prior Authorization Requirement

For Network Benefits you must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don’t obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Network Benefits will not be paid. Non-Network Benefits will apply.

For Non-Network Benefits you must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses up to a maximum reduction of $500.

In addition, for Non-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).
When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

<table>
<thead>
<tr>
<th>Covered Health Service</th>
<th>Benefit (The Amount We Pay, based on Eligible Expenses)</th>
<th>Apply to the Out-of-Pocket Maximum?</th>
<th>Must You Meet Annual Deductible?</th>
</tr>
</thead>
<tbody>
<tr>
<td>For Network Benefits, transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility in order for you to receive Network Benefits.</td>
<td><strong>Network</strong></td>
<td>Network</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Non-Network</strong></td>
<td>Yes</td>
</tr>
<tr>
<td>41. Urgent Care Center Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In addition to the Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed at an Urgent Care Center:</td>
<td><strong>Network</strong></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Non-Network</strong></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>• Major diagnostic and nuclear medicine described under Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.</td>
<td>80%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Outpatient Pharmaceutical Products described under Pharmaceutical Products - Outpatient.</td>
<td>60%</td>
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<td>• Diagnostic and therapeutic scopic procedures described under Scopic Procedures - Outpatient Diagnostic and Therapeutic.</td>
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<td>• Outpatient surgery procedures described under Surgery - Outpatient.</td>
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<td>• Outpatient therapeutic procedures described under Therapeutic Treatments - Outpatient.</td>
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<tr>
<td>42. Vision Correction after Surgery or Accident</td>
<td><strong>Network</strong></td>
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<tr>
<td>Benefits for the prescription, fitting or purchase of glasses or contact lenses</td>
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</tbody>
</table>
When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

<table>
<thead>
<tr>
<th>Covered Health Service</th>
<th>Benefit (The Amount We Pay, based on Eligible Expenses)</th>
<th>Apply to the Out-of-Pocket Maximum?</th>
<th>Must You Meet Annual Deductible?</th>
</tr>
</thead>
<tbody>
<tr>
<td>after surgery or accident.</td>
<td>Benefits are provided as stated under the <em>Durable Medical Equipment</em> category in this Schedule of Benefits.</td>
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<tr>
<td><strong>Non-Network</strong></td>
<td>Benefits are provided as stated under the <em>Durable Medical Equipment</em> category in this Schedule of Benefits.</td>
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### Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below. For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount we will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the Certificate.

**For Network Benefits**, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

**For Non-Network Benefits**, Eligible Expenses are based on either of the following:

- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on:
  - Negotiated rates agreed to by the non-Network provider and either us or one of our vendors, affiliates or subcontractors, at our discretion.
  - If rates have not been negotiated, then one of the following amounts:
    - Eligible Expenses are determined based on \([110 - 200]\% 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 laboratory service.
      - 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.
    - 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. The relative value scale is usually based on the difficulty, time,
work, risk 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] 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 is not published by CMS for the service and a gap methodology does not apply to the service, the Eligible Expense is based on 50% of the provider’s billed charge.

- For Mental Health Services and Substance Use Disorder Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

We update the CMS published rate data on a regular basis when updated data from CMS becomes available. These updates are typically implemented within 30 to 90 days after CMS updates its data.

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

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on [110-200]% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market with the exception of the following:

- 50% of CMS for the same or similar laboratory service.
- 45% of CMS for the same or similar durable medical equipment, or CMS competitive bid rates.

When a rate is not published by CMS for the service, we use a gap methodology established by OptumInsight and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes 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] 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 is not published by CMS for the service and a gap methodology does not apply to the service, the Eligible Expense is based on 50% of the provider’s billed charge.

For Mental Health Services and Substance Use Disorder Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

**IMPORTANT NOTICE:** Non-Network facility based Physicians may bill you for any difference between the Physician’s billed charges and the Eligible Expense described here.
For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.

When a rate is not published by CMS for the service, we use a gap methodology established by OptumInsight and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes 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] 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 is not published by CMS for the service and a gap methodology does not apply to the service, the Eligible Expense is based on 50% of the provider's billed charge.

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

When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select 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 Customer Care. A directory of providers is available online at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card to request a copy.

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.

If you are currently undergoing a course of treatment utilizing a non-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 determining whether you are eligible for transition of care Benefits, please contact Customer Care at the telephone number on your ID card.

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

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health 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 Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses at our discretion.

In both cases, Network Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other 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 Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Network Benefits will not be paid. Non-Network Benefits may be available if the special needs services you receive are Covered Health Services for which Benefits are provided under the Policy.

Health Services from Non-Network Providers Paid as Network Benefits

If specific Covered Health Services are not available from a Network provider, you may be eligible for Network Benefits when Covered Health Services are received from non-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 a non-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 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 fail to use the selected Network Physician, Covered Health Services will be paid as Non-Network Benefits.
Outpatient Prescription Drug Rider

UnitedHealthcare Insurance Company

This Rider to the Policy is issued to the Enrolling Group and provides Benefits for Prescription Drug Products.

Because this Rider is part of a legal document, 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 either the Certificate of Coverage (Certificate) in Section 9: Defined Terms or in this Rider in Section 3: 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 the term is defined in the Certificate in Section 9: Defined Terms.

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

_____________________________
(Name and Title)
Introduction

Coverage Policies and Guidelines

Our Prescription Drug List (PDL) Management Committee is authorized to make tier placement changes on our behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or prior authorization requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, available rebates and assessments on the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are more cost effective for specific indications as compared to others; therefore, a Prescription Drug Product may be listed on multiple tiers according to the indication for which the Prescription Drug Product was prescribed, or according to whether it was prescribed by a Specialist Physician.

We may periodically change the placement of a Prescription Drug Product among the tiers. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may occur 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 an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

NOTE: The tier status of a Prescription Drug Product may change periodically 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 access www.myuhc.com through the Internet or call Customer Care at the telephone number on your ID card for the most up-to-date tier status.

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 will be required to 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 failed to 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 Copayment and/or Coinsurance, Ancillary Charge, and any deductible that applies.

Submit your claim to OptumRx.

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 are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, you will be subject to the non-Network Benefit for that Prescription Drug Product.
Limitation on 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 selection of Network Pharmacies may be limited. If this happens, we may require you to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within 31 days of the date we notify you, we will select a single Network Pharmacy for you.

If you disagree with our decision, you may ask us to reconsider as described in Section 6: Questions, Complaints and Appeals of the Certificate of Coverage (Certificate).

Rebates and Other Payments

We may receive rebates for certain drugs included on the Prescription Drug List. We do not pass these rebates on to you, nor are they taken into account in determining your Copayments and/or Coinsurance.

We, and a number of our affiliated entities, conduct business with various pharmaceutical manufacturers separate and apart from this Outpatient Prescription Drug Rider. 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 Rider. 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 to you or to your Physician that communicate a variety of messages, including information about Prescription Drug Products. These mailings may contain coupons or offers from pharmaceutical manufacturers that enable you, at your discretion, to purchase the described drug product at a discount or to obtain it at no charge. Pharmaceutical manufacturers may pay for and/or provide the content for these mailings. Only your Physician can determine whether a change in your Prescription Order or Refill is appropriate for your medical condition.

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 participation in health management programs. You may access information on these programs through the Internet at www.myuhc.com or by calling Customer Care at 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 to obtain those Maintenance Medications. If you choose not to obtain your Maintenance Medications from the Mail Order Network Pharmacy, you may opt-out of the Maintenance Medication Program each year through the Internet at www.myuhc.com or by calling Customer Care at the telephone number on your ID card.

Prescription Drug Products Prescribed by a Specialist Physician

You may receive an enhanced or reduced Benefit, or no Benefit, based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to Benefit enhancement, reduction or no Benefit through the Internet at www.myuhc.com or by calling Customer Care at the telephone number on your ID card.

Continuity of Prescriptions

If you have been receiving a prescription drug based on a prior authorization from another insurer, and your coverage with that insurer has been replaced with coverage under this Policy, we will honor your prior insurer's prior authorization of the prescription drug, for a period not to exceed 6 months, until we
have the opportunity to conduct a review with your prescribing provider. We are not required to provide benefits under this section for conditions or services not otherwise covered under this Policy and your cost sharing responsibility will be based on any applicable Copayment, Coinsurance or deductible requirements of this Policy.
Section 1: Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at either a Network Pharmacy or a non-Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed. Refer to the Outpatient Prescription Drug Schedule of Benefits for applicable Copayments and/or Coinsurance requirements.

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

Benefits for Prescription Drug Products are available for outpatient Prescription Drug Products provided as part of an approved clinical trial. You must meet the following conditions:

- You have a life-threatening illness (one which is likely to cause death within one year) for which no standard treatment is effective.
- You are eligible to participate according to the clinical trial protocol with respect to such illness.
- Your participation in the trial offers meaningful potential for significant clinical benefit to you.
- Your referring Physician has concluded that your participation in such a trial would be appropriate based upon the satisfaction of the above conditions.

Benefits are available for refills of Prescription Drug Products only when dispensed as ordered by a duly licensed health care provider and only after 3/4 of the original Prescription Drug Product has been used.

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 choose not to obtain your Specialty Prescription Drug Product from a Designated Pharmacy, you will be subject to the non-Network Benefit for that Specialty Prescription Drug Product.

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

Refer to the Outpatient Prescription Drug Schedule of Benefits for details on Specialty Prescription Drug Product supply limits.

Prescription Drugs from a Retail Network Pharmacy

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

Refer to the Outpatient Prescription Drug Schedule of Benefits for details on retail Network Pharmacy supply limits.

Prescription Drugs from a Retail Non-Network Pharmacy

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

If the Prescription Drug Product is dispensed by a retail non-Network Pharmacy, you must pay for the Prescription Drug Product at the time it is dispensed and then 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 Predominant Reimbursement Rate and the non-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 a non-Network Pharmacy.

Refer to the Outpatient Prescription Drug Schedule of Benefits for details on retail non-Network Pharmacy supply limits.

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Prescription Drug Products from a Mail Order Network Pharmacy

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy.

Refer to the Outpatient Prescription Drug Schedule of Benefits for details on mail order Network Pharmacy supply limits.

Please access www.myuhc.com through the Internet or call Customer Care at the telephone number on your ID card to determine 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.

Orally Administered Cancer Therapy

Coverage for orally administered anticancer Prescription Drug Products from a retail or mail order Network Pharmacy is provided at an equivalent level to that of intravenously administered or injected anticancer medications, regardless of tier placement. This includes orally administered anticancer medications that are Specialty Prescription Drug Products.
Section 2: Exclusions

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

When an exclusion applies to only certain Prescription Drug Products, you can access www.myuhc.com through the Internet or call Customer Care at 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.


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 indications and/or dosage regimens determined by us to be experimental, investigational or unproven.

This exclusion does not apply to the off-label use of a Prescription Drug Product prescribed to treat cancer or HIV/AIDS if such Prescription Drug Product is recognized for treatment in any of the standard reference compendia.

This exclusion does not apply to outpatient Prescription Drug Products provided as part of an approved clinical trial as described in Section 1: Benefits for Prescription Drug Products.

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. This exclusion does not apply to you if your workers’ compensation claim has been controverted and you are awaiting a Workers’ Compensation Board determination.

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 exclusion does not apply to Depo Provera and other injectable drugs used for contraception.

10. Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the 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, and single entity vitamins.

12. 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 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.
17. Certain Prescription Drug Products for smoking 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. 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 comprised 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, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

19. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by our PDL Management Committee.

20. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).

21. Any oral non-sedating antihistamine or antihistamine-decongestant combination.

22. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury except as described in Section 1: Covered Health Services of the Certificate of Coverage under the headings Medical Foods and Infant Formula.

23. Prescription Drug Products designed to adjust sleep schedules, such as for jet lag or shift work.

24. Prescription Drug Products when prescribed as sleep aids.

25. 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, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

26. 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, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

27. Certain Prescription Drug Products that have not been prescribed by a Specialist Physician.

28. A Prescription Drug Product that contains marijuana, including medical marijuana.

29. Certain Prescription Drug Products that exceed the minimum number of drugs required to be covered under 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.
Section 3: Defined Terms

Ancillary Charge - a charge, in addition to the Copayment and/or Coinsurance, that you are required to 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 on a lower tier. For Prescription Drug Products from Network Pharmacies, the Ancillary Charge is calculated as the difference between the Prescription Drug Charge or Maximum Allowable Cost (MAC) List price for Network Pharmacies for the Prescription Drug Product on the higher tier, and the Prescription Drug Charge or Maximum Allowable Cost (MAC) List price of the Chemically Equivalent Prescription Drug Product available on the lower tier. For Prescription Drug Products from non-Network Pharmacies, the Ancillary Charge is calculated as the difference between the Predominant Reimbursement Rate or Maximum Allowable Cost (MAC) List price for non-Network Pharmacies for the Prescription Drug Product on the higher tier, and the Predominant Reimbursement Rate or Maximum Allowable Cost (MAC) List price of the Chemically Equivalent Prescription Drug Product available on the lower tier.

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 including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician may not 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, including, but not limited to, Specialty Prescription Drug Products. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

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 including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by us.

Maintenance Medication - a Prescription Drug Product anticipated to be used for six months or more to treat or prevent a chronic condition. You may determine whether a Prescription Drug Product is a Maintenance Medication through the Internet at www.myuhc.com or by calling Customer Care at the telephone number on your ID card.

Maximum Allowable Cost (MAC) List - a list of Generic Prescription Drug Products that will be covered at a price level that we establish. This list is subject to our periodic review and modification.

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 assigned to a tier by our PDL Management Committee.
- December 31st of the following calendar year.

Predominant Reimbursement Rate - the amount we will pay to reimburse you for a Prescription Drug Product that is dispensed at a non-Network Pharmacy. The Predominant Reimbursement Rate for a RDR.RX.PLS.ACA15.I.11.ME.SB
particular Prescription Drug Product dispensed at a non-Network Pharmacy includes a dispensing fee and any applicable sales tax. We calculate the Predominant Reimbursement Rate using our Prescription Drug Charge that applies for that particular Prescription Drug Product at most Network Pharmacies.

**Prescription Drug Charge** - the rate we have agreed to pay our Network Pharmacies, including the applicable dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

**Prescription Drug List** - a list that categorizes into tiers medications, products or devices that have been approved by the U.S. Food and Drug Administration (FDA). This list is subject to our periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Prescription Drug Product has been assigned through the Internet at www.myuhc.com or by calling Customer Care at the telephone number on your ID card.

**Prescription Drug List (PDL) Management Committee** - the committee that we designate for, among other responsibilities, classifying Prescription Drug Products into specific tiers.

**Prescription Drug Product** - a medication, product or device that has been approved by the U.S. Food and Drug Administration (FDA) and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is 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.
- Oral hypoglycemic agents.
- 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 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 permits 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. You may access a complete list of Specialty Prescription Drug Products through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

**Therapeutic Class** - a group or category of Prescription Drug Products with similar uses and/or actions.

**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. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax.
Outpatient Prescription Drug
UnitedHealthcare Insurance Company
Schedule of Benefits

Benefits for Prescription Drug Products
Benefits are available for Prescription Drug Products at either a Network Pharmacy or a non-Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

The Prescription Drug List categorizes into tiers medications, products or devices that have been approved by the U.S. Food and Drug Administration. This list is subject to our periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Prescription Drug Product has been assigned through the Internet at www.myuhc.com or by calling Customer Care at the telephone number on your ID card.

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

If 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, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply. You will pay the Copayment and/or Coinsurance applicable for the tier to which the Prescription Drug Product is assigned.

Supply Limits
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 Copayment and/or Coinsurance, 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, subject to our periodic review and modification. The limit may restrict 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 determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at [www.myuhc.com] or by calling Customer Care at the telephone number on your ID card.

Prior Authorization Requirements
Before certain Prescription Drug Products are dispensed to you, either 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 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 Physician.
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.

Non-Network Pharmacy Prior Authorization
When Prescription Drug Products are dispensed at a non-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 to our periodic review and modification. You may determine whether a particular Prescription Drug Product requires prior authorization through the Internet at www.myuhc.com or by calling Customer Care at 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 a non-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 Predominant Reimbursement Rate (for Prescription Drug Products from a non-Network Pharmacy), less the required Copayment and/or Coinsurance, 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 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 associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at www.myuhc.com or by calling Customer Care at the telephone number on your ID card.

Step Therapy
Certain Prescription Drug Products for which Benefits are described under this Prescription Drug Rider or Pharmaceutical Products for which Benefits are described in your Certificate are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at www.myuhc.com or by calling Customer Care at the telephone number on your ID card.

What You Must Pay
You are responsible for paying the Annual Deductible stated in the Schedule of Benefits which is attached to your Certificate before Benefits for Prescription Drug Products under this Rider are available to you.

Benefits for Preventive Care Medications are not subject to payment of the Annual Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care 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 the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the lower tiered drug. An Ancillary Charge does not apply to any Annual Deductible.

The amount you pay for any of the following under this Rider will not be included in calculating any Out-of-Pocket Maximum stated in your Certificate:

- The difference between the Predominant Reimbursement Rate and a non-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 and our contracted rates (our Prescription Drug Charge) will not be available to you.
Payment Information

<table>
<thead>
<tr>
<th>Payment Term And Description</th>
<th>Amounts</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Copayment and Coinsurance</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Copayment</strong></td>
<td>Copayment for a Prescription Drug Product at a Network or non-Network Pharmacy is a specific dollar amount.</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge.</td>
</tr>
<tr>
<td></td>
<td>Coinsurance for a Prescription Drug Product at a non-Network Pharmacy is a percentage of the Predominant Reimbursement Rate.</td>
</tr>
<tr>
<td><strong>Copayment and Coinsurance</strong></td>
<td>Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product.</td>
</tr>
<tr>
<td></td>
<td>We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance if the combination of these multiple products provides a therapeutic treatment regimen that is supported by available clinical evidence.</td>
</tr>
<tr>
<td></td>
<td>You may determine whether a therapeutic treatment regimen qualifies for a single Copayment and/or Coinsurance through the Internet at <a href="http://www.myuhc.com">www.myuhc.com</a> or by calling Customer Care at the telephone number on your ID card.</td>
</tr>
<tr>
<td></td>
<td>Your Copayment and/or Coinsurance 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 associated with such programs.</td>
</tr>
<tr>
<td></td>
<td>You may access information on these programs and any applicable prior authorization, participation or activation requirements associated with such programs.</td>
</tr>
</tbody>
</table>

For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of the following:

- The applicable Copayment and/or Coinsurance.
- The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product.

For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following:

- The applicable Copayment and/or Coinsurance.
- The Prescription Drug Charge for that Prescription Drug Product.

See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts.

You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.
**Payment Term And Description**  
programs through the Internet at www.myuhc.com or by calling Customer Care at the telephone number on your ID card.

**Special Programs:** We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance 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 through the Internet at www.myuhc.com or by calling Customer Care at the telephone number on your ID card.

**Copayment/Coinsurance Waiver Program:** 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 Copayment and/or Coinsurance for one or more Prescription Orders or Refills.

**Prescription Drug Products Prescribed by a Specialist Physician:** You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at www.myuhc.com or by calling Customer Care at the telephone number on your ID card.

**NOTE:** The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee’s periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access www.myuhc.com through the Internet or

<table>
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<td>programs through the Internet at <a href="http://www.myuhc.com">www.myuhc.com</a> or by calling Customer Care at the telephone number on your ID card.</td>
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</tr>
<tr>
<td><strong>Special Programs:</strong> We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance 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 through the Internet at <a href="http://www.myuhc.com">www.myuhc.com</a> or by calling Customer Care at the telephone number on your ID card.</td>
<td></td>
</tr>
<tr>
<td><strong>Copayment/Coinsurance Waiver Program:</strong> 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 Copayment and/or Coinsurance for one or more Prescription Orders or Refills.</td>
<td></td>
</tr>
<tr>
<td><strong>Prescription Drug Products Prescribed by a Specialist Physician:</strong> You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at <a href="http://www.myuhc.com">www.myuhc.com</a> or by calling Customer Care at the telephone number on your ID card.</td>
<td></td>
</tr>
<tr>
<td><strong>NOTE:</strong> The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee’s periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access <a href="http://www.myuhc.com">www.myuhc.com</a> through the Internet or</td>
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</tr>
<tr>
<td>Payment Term And Description</td>
<td>Amounts</td>
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<tr>
<td>call <em>Customer Care</em> at the telephone number on your ID card for the most up-to-date tier status. <strong>Coupons:</strong> We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at <a href="http://www.myuhc.com">www.myuhc.com</a> or by calling <em>Customer Care</em> at the telephone number on your ID card.</td>
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</table>
## Benefit Information

<table>
<thead>
<tr>
<th>Description and Supply Limits</th>
<th>Benefit (The Amount We Pay)</th>
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</thead>
<tbody>
<tr>
<td><strong>Specialty Prescription Drug Products</strong></td>
<td><strong>Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Specialty Prescription Drug Product. All Specialty Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2 or Tier 3. Please access <a href="http://www.myuhc.com">www.myuhc.com</a> through the Internet or call Customer Care at the telephone number on your ID card to determine tier status.</strong></td>
</tr>
<tr>
<td>The following supply limits apply.</td>
<td><strong>Network Pharmacy</strong></td>
</tr>
<tr>
<td>• 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. 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 Copayment and/or Coinsurance that applies will reflect the number of days dispensed. Supply limits apply to Specialty Prescription Drug Products obtained at a Network Pharmacy, a non-Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.</td>
<td>For a Tier 1 Specialty Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $10 per Prescription Order or Refill. For a Tier 2 Specialty Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $100 per Prescription Order or Refill. For a Tier 3 Specialty Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $300 per Prescription Order or Refill.</td>
</tr>
<tr>
<td><strong>Non-Network Pharmacy</strong></td>
<td>For a Tier 1 Specialty Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of $10 per Prescription Order or Refill. For a Tier 2 Specialty Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of $100 per Prescription Order or Refill. For a Tier 3 Specialty Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of $300 per Prescription Order or Refill.</td>
</tr>
<tr>
<td><strong>Prescription Drugs from a Retail Network Pharmacy</strong></td>
<td><strong>Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, or Tier 3. Please access <a href="http://www.myuhc.com">www.myuhc.com</a> through the Internet or call Customer Care at the telephone number on your ID card to determine tier status.</strong></td>
</tr>
<tr>
<td>The following supply limits apply:</td>
<td>For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $10 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $30 per Prescription Order or Refill.</td>
</tr>
<tr>
<td>• 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.</td>
<td>For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $30 per Prescription Order or Refill.</td>
</tr>
<tr>
<td>• A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or</td>
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RDR.RXSBN.PL.S.ACA15.I.11.ME.SB.YI

7
### Description and Supply Limits

**Benefit (The Amount We Pay)**

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<thead>
<tr>
<th>Description and Supply Limits</th>
<th>Benefit (The Amount We Pay)</th>
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</thead>
</table>
| Coinsurance for each cycle supplied.  
When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed. | Refill.  
For a Tier 3 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $50 per Prescription Order or Refill. |

### Prescription Drugs from a Retail Non-Network Pharmacy

The following supply limits apply:

- 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.

- A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied.

When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.

Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, or Tier 3. Please access www.myuhc.com through the Internet or call Customer Care at the telephone number on your ID card to determine tier status.

For a Tier 1 Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of $10 per Prescription Order or Refill.

For a Tier 2 Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of $30 per Prescription Order or Refill.

For a Tier 3 Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of $50 per Prescription Order or Refill.

### Prescription Drug Products from a Mail Order Network Pharmacy

The following supply limits apply:

- 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, including Specialty Prescription Drug Products on the List of Preventive Medication.  
Specialty Prescription Drug

Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, and Tier 3. Please access www.myuhc.com through the Internet or call Customer Care at the telephone number on your ID card to determine tier status.

For up to a 90-day supply, we pay:

For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $25 per Prescription Order or Refill.

For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $75 per Prescription Order or Refill.
<table>
<thead>
<tr>
<th><strong>Description and Supply Limits</strong></th>
<th><strong>Benefit (The Amount We Pay)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Products from a mail order Network Pharmacy are subject to the supply limits stated above under the heading Specialty Prescription Drug Products. You may be required to fill an initial Prescription Drug Product order and obtain 2 refills through a retail pharmacy prior to using a mail order Network Pharmacy. 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 mail order Copayment and/or Coinsurance for any Prescription Orders or Refills sent to the mail order pharmacy regardless of the number-of-days' supply written on the Prescription Order or Refill. Be sure your Physician writes your Prescription Order or Refill for a 90-day supply, not a 30-day supply with three refills.</td>
<td>Refill. For a Tier 3 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of $125 per Prescription Order or Refill.</td>
</tr>
</tbody>
</table>
Pediatric Dental Services Rider

UnitedHealthcare Insurance Company

This Rider to the Policy is issued to the Enrolling Group and provides Benefits for Covered Dental Services, as described below, for Covered Persons under the age of 19. Benefits under this Rider terminate on the date the Covered Person reaches the age of 19.

Because this Rider is part of a legal document, 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 either the Certificate of Coverage (Certificate) in Section 9: Defined Terms or in this Rider in Section 5: Defined Terms for Pediatric Dental Services.

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 the term is defined in the Certificate in Section 9: Defined Terms.

__________________________
(Name and Title)
Section 1: Accessing Pediatric Dental Services

Network and Non-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 a non-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 in excess of 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 verify the participation status of a provider prior to seeking services. From time to time, the participation status of a provider may change. You can verify the participation status by calling us and/or the provider. If necessary, we can provide assistance in referring you to Network Dental Provider.

We will make available to you a Directory of Network Dental Providers. You can also call Customer Service to determine which providers participate in the Network. The telephone number for Customer Service is on your ID card.

Non-Network Benefits - these Benefits apply when you decide to obtain Covered Dental Services from non-Network Dental Providers. You generally are required to pay more to the provider than for Network Benefits. Non-Network Benefits are determined based on the Usual and Customary fee for similarly situated Network Dental Providers for each Covered Dental Service. The actual charge made by a non-Network Dental Provider for a Covered Dental Service may exceed the Usual and Customary fee. As a result, you may be required to pay a non-Network Dental Provider an amount for a Covered Dental Service in excess of the Usual and Customary fee. In addition, when you obtain Covered Dental Services from non-Network Dental Providers, you must file a claim with us to be reimbursed for Eligible Dental Expenses.

Covered Dental Services

You are eligible for Benefits for Covered Dental Services listed in this Rider 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 Rider.

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 assigned 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.
Pre-Authorization
Pre-authorization is required for orthodontic services. Speak to your Dental Provider about obtaining a pre-authorization before Dental Services are rendered. If you do not obtain a pre-authorization, we have a right to deny your claim for failure to comply with this requirement.

Section 2: 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 assigned a Benefit based on the least costly procedure.
D. Not excluded as described in Section 3: Pediatric Dental Services exclusions of this Rider.

Network Benefits:
Benefits for Eligible Dental Expenses 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 as determined by us. 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.

Non-Network Benefits:
Benefits for Eligible Dental Expenses from non-Network providers are determined as a percentage of the Usual and Customary fees. You must pay the amount by which the non-Network provider’s billed charge exceeds the Eligible Dental Expense.

Annual Deductible
Benefits for pediatric Dental Services provided under this Rider are subject to the Annual Deductible stated in the Schedule of Benefits.

Out-of-Pocket Maximum - any amount you pay in Coinsurance for pediatric Dental Services under this Rider applies to the Out-of-Pocket Maximum stated in the Schedule of Benefits.

Benefits
When Benefit limits apply, the limit stated refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

Benefit limits are calculated on a Policy year basis unless otherwise specifically stated.

Benefit Description

<table>
<thead>
<tr>
<th>Benefit Description and Limitations</th>
<th>Network Benefits</th>
<th>Non-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnostic Services - (Subject to payment of the Annual Deductible.)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intraoral Bitewing Radiographs (Bitewing X-ray)</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Limited to 2 series of films per
<table>
<thead>
<tr>
<th>Benefit Description and Limitations</th>
<th>Network Benefits</th>
<th>Non-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
</tr>
<tr>
<td>12 months.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays)</em>&lt;br&gt; Limited to 1 time per 36 months.</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><em>Periodic Oral Evaluation (Check up Exam)</em>&lt;br&gt; 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.</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Preventive Services - (Subject to payment of the Annual Deductible.)**

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Network Benefits</th>
<th>Non-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Dental Prophylaxis (Cleanings)</em>&lt;br&gt; Limited to 2 times per 12 months.</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><em>Fluoride Treatments</em>&lt;br&gt; Limited to 2 times per 12 months. Treatment should be done in conjunction with dental prophylaxis.</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><em>Sealants (Protective Coating)</em>&lt;br&gt; Limited to once per first or second permanent molar every 36 months.</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><em>Space Maintainers (Spacers)</em>&lt;br&gt; Limited to 1 per 60 months. Benefit includes all adjustments within 6 months of installation.</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Minor Restorative Services, Endodontics, Periodontics and Oral Surgery - (Subject to payment of the Annual Deductible.)**

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Network Benefits</th>
<th>Non-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Amalgam Restorations (Silver Fillings)</em>&lt;br&gt; Multiple restorations on one surface will be treated as a single filling.</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Benefit Description and Limitations</td>
<td>Network Benefits</td>
<td>Non-Network Benefits</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td></td>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
</tr>
<tr>
<td><strong>Composite Resin Restorations</strong></td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td><em>(Tooth Colored Fillings)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>For anterior (front) teeth only.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Endodontics (Root Canal Therapy)</strong></td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Limited to 1 time per tooth per lifetime.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Periodontal Surgery (Gum Surgery)</strong></td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Limited 1 quadrant or site per 36 months per surgical area.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Scaling and Root Planing</strong></td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td><em>(Deep Cleanings)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limited to 1 time per quadrant per 24 months.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Periodontal Maintenance (Gum Maintenance)</strong></td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Limited to 2 times per 12 month period following active and adjunctive periodontal therapy, exclusive of gross debridement.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Simple Extractions</strong></td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td><em>(Simple tooth removal)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limited to 1 time per tooth per lifetime.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Oral Surgery, including Surgical Extraction</strong></td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Adjunctive Services - (Subject to payment of the Annual Deductible.)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>General Services (including Emergency Treatment)</strong></td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Covered as a separate Benefit only if no other service was done during the visit other than X-rays.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General anesthesia is covered when clinically necessary.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occlusal guard limited to 1 guard every 12 months.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefit Description and Limitations</td>
<td>Network Benefits</td>
<td>Non-Network Benefits</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td></td>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
</tr>
</tbody>
</table>

**Major Restorative Services - (Subject to payment of the Annual Deductible.)**

Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the Policy is limited to 1 time per 60 months from initial or supplemental placement.

- **Inlays/Onlays/Crowns (Partial to Full Crowns)**
  - Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.
  - 50%
  - 50%

- **Fixed Prosthetics (Bridges)**
  - Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.
  - 50%
  - 50%

- **Removable Prosthetics (Full or partial dentures)**
  - Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.
  - 50%
  - 50%

- **Relining and Rebasing Dentures**
  - Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.
  - 50%
  - 50%

- **Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges, or Crowns**
  - Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6 months.
  - 50%
  - 50%

**Implants - (Subject to payment of the Annual Deductible.)**

- **Implant Placement**
  - Limited to 1 time per 60 months.
  - 50%
  - 50%

- **Implant Supported Prosthetics**
  - 50%
  - 50%
<table>
<thead>
<tr>
<th>Benefit Description and Limitations</th>
<th>Network Benefits</th>
<th>Non-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
</tr>
<tr>
<td>Limited to 1 time per 60 months.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Implant Maintenance Procedures</strong></td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limited to 1 time per 60 months.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Repair Implant Supported Prosthesis by Report</strong></td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Limited to 1 time per 60 months.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium</strong></td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Limited to 1 time per 60 months.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Repair Implant Abutment by Support</strong></td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Limited to 1 time per 60 months.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Radiographic/Surgical Implant Index by Report</strong></td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Limited to 1 time per 60 months.</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>

**Medically Necessary Orthodontics - (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.
<table>
<thead>
<tr>
<th>Benefit Description and Limitations</th>
<th>Network Benefits</th>
<th>Non-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
</tr>
<tr>
<td>Orthodontic Services</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>

**Section 3: Pediatric Dental Exclusions**

Except as may be specifically provided in this Rider under **Section 2: Benefits for Covered Dental Services**, Benefits are not provided under this Rider for the following:

1. Any Dental Service or Procedure not listed as a Covered Dental Service in this Rider in **Section 2: Benefits for Covered Dental Services**.
2. Dental Services that are not Necessary.
3. Hospitalization or other facility charges.
4. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
5. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, Injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.
6. Any Dental Procedure not directly associated with dental disease.
7. Any Dental Procedure not performed in a dental setting.
8. 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.
9. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
10. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
11. 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.
12. 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.
13. 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.

14. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.

15. Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled for coverage provided through this Rider to the Policy.

16. Dental Services otherwise covered under the Policy, but rendered after the date individual coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy terminates.

17. Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person’s family, including spouse, brother, sister, parent or child.

18. Foreign Services are not covered unless required as an Emergency.

19. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.

20. Procedures related to the reconstruction of a patient’s correct vertical dimension of occlusion (VDO).

21. Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service.

22. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.

23. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.

24. 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.

Section 4: Claims for Pediatric Dental Services

When obtaining Dental Services from a non-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 the Certificate in Section 5: How to File a Claim apply to Covered Dental Services provided under this Rider, except that when you submit your claim, you must provide us with all of the information identified 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 rendered 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.

Section 5: Defined Terms for Pediatric Dental Services

The following definitions are in addition to those listed in Section 9: Defined Terms of the Certificate:

Covered Dental Service – a Dental Service or Dental Procedure for which Benefits are provided under this Rider.

Dental Provider - any dentist or dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to render Dental Services, perform dental surgery or administer 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.

Eligible Dental Expenses - Eligible Dental Expenses 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, Eligible Dental Expenses are our contracted fee(s) for Covered Dental Services with that provider.

• For Non-Network Benefits, when Covered Dental Services are received from Non-Network Dental Providers, Eligible Dental Expenses are the Usual and Customary fees, as defined below.

Necessary - Dental Services and supplies under this Rider which are determined by us 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.

• Rendered 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 Rider. The definition of Necessary used in this Rider relates only to Benefits under this Rider and differs from the way in which a Dental Provider engaged in the practice of dentistry may define necessary.

**Usual and Customary** - Usual and Customary fees are calculated by us based on available data resources of competitive fees in that geographic area.

Usual and Customary fees must not exceed the fees that the provider would charge any similarly situated payor for the same services.

Usual and Customary fees are determined solely in accordance with our reimbursement policy guidelines. Our reimbursement policy guidelines are developed by us, in our discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (publication of the American Dental Association).
- As reported by generally recognized professionals or publications.
- As utilized for Medicare.
- As determined by medical or dental staff and outside medical or dental consultants.
- Pursuant to other appropriate source or determination that we accept.
Pediatric Vision Care Services Rider

UnitedHealthcare Insurance Company

This Rider to the Policy is issued to the Enrolling Group and provides Benefits for Vision Care Services, as described below, for Covered Persons under the age of 19. Benefits under this Rider terminate on the date the Covered Person reaches the age of 19.

Because this Rider is part of a legal document, 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 either the Certificate of Coverage (Certificate) in Section 9: Defined Terms or in this Rider in Section 4: Defined Terms for Pediatric Vision Care Services.

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 the term is defined in the Certificate in Section 9: Defined Terms.

__________________________
(Name and Title)
Section 1: Benefits for Pediatric Vision Care Services

Benefits are available for pediatric Vision Care Services from a Spectera Eyecare Networks or non-Network Vision Care Provider. To find a Spectera Eyecare Networks Vision Care Provider, you may call the provider locator service at 1-800-839-3242. You may also access a listing of Spectera Eyecare Networks Vision Care Providers on the Internet at www.myuhcvision.com.

When you obtain Vision Care Services from a non-Network Vision Care Provider, you will be required to pay all billed charges at the time of service. You may then seek reimbursement from us as described in the Certificate in Section 5: How to File a Claim and in this Rider under Section 3: Claims for Vision Care Services. Reimbursement will be limited to the amounts stated below.

When obtaining these Vision Care Services from a Spectera Eyecare Networks Vision Care Provider, you will be required to pay any Copayments at the time of service.

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.

Non-Network Benefits:

Benefits for Vision Care Services from non-Network providers are determined as a percentage of the provider's billed charge.

Out-of-Pocket Maximum - any amount you pay in Coinsurance for Vision Care Services under this Rider applies to the Out-of-Pocket Maximum stated in the Schedule of Benefits. Any amount you pay in Copayments for Vision Care Services under this Rider applies to the Out-of-Pocket Maximum stated in the Schedule of Benefits.

Annual Deductible

Benefits for pediatric Vision Care Services provided under this Rider are subject to any Annual Deductible stated in the Schedule of Benefits. Any amount you pay in Copayments for Vision Care Services under this Rider does not apply to the Annual Deductible stated in the Schedule of Benefits.

Benefit Description

Benefits

When Benefit limits apply, the limit stated refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

Benefit limits are calculated on either a calendar or Policy year basis as applicable 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 Copayments and Coinsurance stated under each Vision Care Service in the Schedule of Benefits below.

Routine Vision Examination

A routine vision examination of the condition of the eyes and principal vision functions according to the standards of care in the jurisdiction in which you reside, including:

- A case history that includes chief complaint and/or reason for examination, patient medical/eye history, and current medications.
- Recording of monocular and binocular visual acuity, far and near, with and without present correction (for example, 20/20 and 20/40).
• Cover test at 20 feet and 16 inches (checks eye alignment).
• Ocular motility including versions (how well eyes track) near point convergence (how well eyes move together for near vision tasks, such as reading), and depth perception.
• Pupil responses (neurological integrity).
• External exam.
• Retinoscopy (when applicable) – objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.
• Phorometry/Binocular testing – far and near: how well eyes work as a team.
• Tests of accommodation and/or near point refraction: how well you see at near point (for example, reading).
• Tonometry, when indicated: test pressure in eye (glaucoma check).
• Ophthalmoscopic examination of the internal eye.
• Confrontation visual fields.
• Biomicroscopy.
• Color vision testing.
• Diagnosis/prognosis.
• Specific recommendations.

Post examination 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 mounted in eyeglass frames and worn on the face to correct visual acuity limitations.

You are eligible to select only one of either eyeglasses (Eyeglass Lenses and/or Eyeglass Frames) or Contact Lenses. If you select more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.

**Lens Extras**
Eyeglass Lenses. The following Lens Extras are covered in full:
• Standard scratch-resistant coating.
• Polycarbonate lenses.

**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 select only one of either eyeglasses (Eyeglass Lenses and/or Eyeglass Frames) or Contact Lenses. If you select more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.

**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 select only one of either eyeglasses (Eyeglass Lenses and/or Eyeglass Frames) or Contact Lenses. If you select 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.

**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 examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated.
- Low vision therapy: Subsequent low vision therapy if prescribed.

**Schedule of Benefits**

<table>
<thead>
<tr>
<th>Vision Care Service</th>
<th>Frequency of Service</th>
<th>Network Benefit</th>
<th>Non-Network Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Routine Vision Examination or Refraction only in lieu of a complete exam.</strong></td>
<td>Once per year.</td>
<td>80% Not subject to payment of the Annual Deductible.</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Eyeglass Lenses</strong></td>
<td>Once per year.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>• <strong>Single Vision</strong></td>
<td></td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>• <strong>Bifocal</strong></td>
<td></td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>• <strong>Trifocal</strong></td>
<td></td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>• <strong>Lenticular</strong></td>
<td></td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Vision Care Service</td>
<td>Frequency of Service</td>
<td>Network Benefit</td>
<td>Non-Network Benefit</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>---------------------</td>
<td>-----------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Eyeglass Frames</td>
<td>Once per year.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Eyeglass frames with a retail cost up to $130.</td>
<td></td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>• Eyeglass frames with a retail cost of $130 - 160.</td>
<td></td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>• Eyeglass frames with a retail cost of $160 - 200.</td>
<td></td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>• Eyeglass frames with a retail cost of $200 - 250.</td>
<td></td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>• Eyeglass frames with a retail cost greater than $250.</td>
<td></td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Contact Lenses Fitting &amp; Evaluation</td>
<td>Once per year.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Covered Contact Lens Selection</td>
<td>Limited to a 12 month supply.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>• Necessary Contact Lenses</td>
<td>Limited to a 12 month supply.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Low Vision Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Note that Benefits for these services will paid as reimbursements. When obtaining these Vision 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.</td>
<td>Once every 24 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Low vision testing</td>
<td></td>
<td>100% of billed charges</td>
<td>75% of billed charges</td>
</tr>
<tr>
<td>• Low vision therapy</td>
<td></td>
<td>75% of billed charges</td>
<td>75% of billed charges</td>
</tr>
</tbody>
</table>
Section 2: Pediatric Vision Exclusions
Except as may be specifically provided in this Rider under Section 1: Benefits for Pediatric Vision Care Services, Benefits are not provided under this Rider 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 the Certificate.
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 Section 1: Benefits for Vision Care Services.
5. Missed appointment charges.
6. Applicable sales tax charged on Vision Care Services.

Section 3: Claims for Pediatric Vision Care Services
When obtaining Vision Care Services from a non-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 the Certificate in Section 5: How to File a Claim applies to Vision Care Services provided under this Rider, 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 rendered by a non-Spectera Eyecare Networks Vision Care Provider, or for Vision Care Services covered as reimbursements (whether or not rendered by a Spectera Eyecare Networks Vision Care Provider or a non-Network Vision Care Provider), you must provide all of the following information:

- Your itemized receipts.
- Covered Person's name.
- Covered Person's identification number from the ID card.
- Covered Person's date of birth.

Submit the above information to us:
By mail:
Claims Department
P.O. Box 30978
Salt Lake City, UT 84130
By facsimile (fax):
248-733-6060

Section 4: Defined Terms for Pediatric Vision Care Services
The following definitions are in addition to those listed in Section 9: Defined Terms of the Certificate:

Covered Contact Lens Selection - a selection of available contact lenses that may be obtained from a Spectera Eyecare Networks Vision Care Provider on a covered-in-full basis, subject to payment of any applicable Copayment.

Spectera Eyecare Networks - 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 Rider in *Section 1: Benefits for Pediatric Vision Care Services.*